HEALTH CARE PROVIDER REINSTATEMENT ATTESTATION

STUDENT INSTRUCTIONS:
Please fill out the top portion of the form, submit it to your health care provider for their signature.

PROVIDER INSTRUCTIONS:
Please fill out and sign the form and then fax to the Student Health & Wellness Center at (503) 494-2958

STUDENT SECTION

I, (Student Name-Please Print)_____hereby authorize the health care provider below to release the information indicated below.

_____
STUDENT SIGNATURE

PROVIDER SECTION

HEALTH CARE PROVIDER PRINTED NAME: _____

HEALTH CARE PROVIDER TITLE: _____

HEALTH CARE PROVIDER LICENSE #: _____

PROVIDER EMAIL:_____ PROVIDER PHONE: _____

I attest that the OHSU student named above is in my care and that this student:

As of the date below, the student named above is capable of meeting the technical standards to be an OHSU student as outlined in the link below.

https://ohsu.ellucid.com/documents/view/20895/?security=3392ffe2df4bea8df4758b49f17a54e9a02ceb47

(If this link is not working, please contact Student Health and Wellness at shw@ohsu.edu).

_____ _____
PROVIDER SIGNATURE DATE OF PROVIDER'S ATTESTATION