University of California, Santa Cruz
**REQUEST FOR MEDICAL INFORMATION**

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**Student Name:** ________________________________ **SID#*:**____________________________

**Name of Physician or Health Care Provider:** _____________________________________________

**Office Address:** _____________________________________________________________

_____________________________________________________________

**Telephone Number:** _____________________________________________________________

**Authorization for Release of Information**

I authorize the Physician or Health Care Provider whose name appears above to provide the following information regarding my medical history and condition(s) to UCSC college/ advising staff.

Student Signature:____________________________________________ Date: ___________

**To the Physician or Health Care Provider:**

The above named student is requesting that s/he be excused from the customary academic responsibilities due to his or her medical condition. S/he requests that you respond to the following questions to the best of your ability so that the college can take into account the effects of his or her condition during the periodic review of academic records. When completed, please return this form to the student who will then submit it to his or her College Academic Preceptor or Adviser.

Dates seen by you for the condition: ______________________________________________________

Please describe the condition in brief (non-technical terms would be appreciated):

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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** The student number requested on this form may be your Social Security Number. In accordance with the Federal Privacy Act of 1974 you are hereby notified that disclosure of your Social Security Number is voluntary. This record keeping system was established pursuant to the authority of the Regents of the University of California under Article IX, Section 9 of the California constitution. The principal use of the number shall be to verify your identity in the Academic Information System and to locate and maintain your academic records.*

**Please describe the likely effect of the medical condition on the student's ability to:**

**1. Attend classes**

Beginning on or about ________________ the student has been (or will be) unable to attend classes for a period of: (date)

☐ A few days ☐ 1 week ☐ 2 weeks ☐ 3 weeks or more ☐ Unknown ☐ Not Applicable

(Check only if applicable)

☐ During the specified period, the student may be able to attend some (but not all) classes. I would estimate that the student's capacity in this regard would be ______% of normal.

Please note any other impact of the medical condition (including effects of medications) on the student's ability to attend classes (optional):

______________________________________________________________________________

______________________________________________________________________________

**2. Complete course work (outside of the classroom)**

Beginning on or about ________________ the student has been (or will be) unable to complete course work for a period of: (date)

☐ A few days ☐ 1 week ☐ 2 weeks ☐ 3 weeks or more ☐ Unknown ☐ Not Applicable

(Check only if applicable)

☐ During the specified period, the student may be able to complete some (but not all) course work assigned. I would estimate that the student's capacity in this regard would be ______% of normal.

Please note any other impact of the medical condition (including effects of medications) on the student's ability to complete course work (optional):

______________________________________________________________________________

______________________________________________________________________________

**Resumption of studies**

After the period specified in 1 and 2 above, the student should be able to attend classes and complete course work as follows (check one):

- ☐ Student will likely be able to resume full-time studies after the above recuperation period has elapsed (40 hours/week workload, roughly equivalent to 15 quarter credits)
- ☐ Student will likely be able to attend classes and complete the work required but at a somewhat reduced level (20-30 hours/week workload, roughly equivalent to 10 quarter credits)
- ☐ Student will likely be able to attend classes and complete the work required but at a greatly reduced level (10-15 hours/week workload, roughly equivalent to 5 quarter credits)
- ☐ Unknown

Additional Comments (optional):

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______________________________________________________________________________

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**Signature of Physician or Health Care Provider:** ____________________________ **Date:** _________

**Degree:** ______ **State:** ________________ **License No.:** __________________