University of California, Santa Cruz
REQUEST FOR MEDICAL INFORMATION

Student Name: ____ ID#:_______________________

Affected Term: ____

Name of Physician or Health Care Provider: ____

Office Address / Phone: ____

Authorization for Release of Information

I authorize the Health Care Provider 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:
This student is requesting that s/he be excused from the customary academic responsibilities due to a medical condition. Please respond to the following questions to the best of your ability so the college can take this medical information into account. When completed, please return this form to the student, who will then submit it to his/her college.

Date of onset of current condition: ____

Date seen by you for condition:____

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

How should we expect the condition to impair the student's ability to handle full-time academic work?
- The student can be expected to perform at approximately ___________________% of normal capacity for _____________________________ days / weeks / months (circle one) from onset.

Do you recommend either of the following (please circle)?:
- Part-time student while impairment persists (one to two classes) Yes No
- Withdrawal from all classes while impairment persists Yes No

Please indicate the approximate date you anticipate the student may be able to resume full-time studies:
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Additional Comments:____
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Signature of Physician / Health Care Provider: ______________________________**Date:** _________________

Degree: __________________ **State:** _____________ **License No.:** ____________________________________