2017-2018 SATISFACTORY ACADEMIC PROGRESS
MEDICAL DOCUMENTATION FORM

Please print clearly—illegible documents cannot be processed

Student Name: ____________________________ Campus ID: ____________________

I am requesting an appeal for the loss of Financial Aid eligibility for the following semester:

☐ Fall 2017 ☐ Spring 2018 ☐ Summer 2018

This **form is required** if you are appealing for one of the following reasons (check one):

☐ Disabling illness or injury to you (student)

☐ Disabling illness or injury of an immediate family member who required your care

☐ Emotional or mental health issue that required you to receive professional care

I give permission for my healthcare provider to supply all information necessary to respond to the questions listed below.

Student/Patient Signature ____________________________________________ Date ____________________________________________

All items in the section below **must be completed in full by a licensed healthcare provider.**

1. Please provide the dates of the student's/family member's condition that prevented the student from attending school or completing class work.

   From:_______________________________________________ To:__________________________________________________

2. Briefly describe the condition and how it prevented the student from attending school and/r completing class work. Use the back of this page is necessary.

   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

3. In your opinion, is the student able to return to school successfully at this time?

   ☐ YES: Recommended level of attendance: ☐ Full-time (12 credits or more) ☐ Part-time (less them 12 credits)

   ☐ NO: You do not recommend attendance at this time

   ☐ Unable to determine at this time: The student/patient will be released on __________________________(date).

Name/Address of healthcare professional: ________________________________________________________________

   Please Print/Use Office Stamp

Signature:___________________________________________ Phone:______________________________________________

Professional Title:____________________________________ Date:______________________________________________