

GENERAL INFORMATION

Students seeking a record adjustment or course refund for medical reasons must submit this form to their medical provider for completion. This form is used to verify the authenticity and severity of circumstances presented.

STUDENT INFORMATION

To be completed by the student.

UVID _____ Name _____

I authorize the release of my medical records and information to Utah Valley University to provide information relevant to my request.

➔ **Student Signature:** _____ **Date:** _____

MEDICAL PROVIDER VERIFICATION

To be completed by the medical provider.

Date(s) student was under your care: _____ Semester(s) Affected: _____

Nature of medical condition/illness/injury/event (brief description): _____

In your medical opinion, do you believe this medical condition/illness/injury/event inhibited the student's ability to be successful in school such that their courses should be withdrawn or factored out of the student's GPA for the semester(s) in question?

Yes

No

Additional comments or recommendations:

MEDICAL PROVIDER INFORMATION AND SIGNATURE

NOTE: The UVU Registrar's Office may confirm with you to ensure that the information provided is authentic.

Printed Name (and post-nominals): _____ License #: _____

Name of Practice/Clinic: _____

Email (if available): _____ Phone: _____

➔ **Signature:** _____ **Date:** _____