

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 the circumstances presented.

STUDENT INFORMATION AND RELEASE

To be completed by the student.

UVID _____ Name _____

I authorize the release of my medical records/information to Utah Valley University to provide details relevant to my request. In accordance with the Family Educational Rights and Privacy Act (FERPA), I also authorize Utah Valley University to share my grades and class schedule information with my medical provider (named below) as needed to accurately evaluate 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 condition/illness/injury/event inhibited the student's ability to be successful in school such that their course(s) should be withdrawn or factored out of the student's GPA for the affected semesters?

Yes No

Additional comments or recommendations:

MEDICAL PROVIDER INFORMATION AND SIGNATURE

The UVU Registrar's Office may contact you to confirm that the information provided on this form is not fraudulent or altered in any way, or to obtain additional clarification regarding the request.

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

Name of Practice/Clinic: _____

Email (if available): _____ Phone: _____

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