

**INSTRUCTIONS:** The lower part of this form should be completed by the appropriate medical professional and the entire form should be returned, along with your completed petition, to OneStop at Florida International University, 1200 SW 8<sup>th</sup> St. PC 130, Miami, FL 33199.

**TO BE COMPLETED BY THE STUDENT:**

Student's Name: \_\_\_\_\_ Panther ID: \_\_\_\_\_

Relevant time Period: \_\_\_\_\_ Affected Semester(s) \_\_\_\_\_

Medical problem pertains to: \_\_\_\_\_ Student

\_\_\_\_\_ Immediate Family Member (please circle one: grandparent, parent, sibling, spouse, or child)

**Must provide written support from their primary health care provider, social worker, or case manager as the primary caregiver.**

I am requesting Dr. \_\_\_\_\_ to release the information requested below to Florida International University for the purpose of supporting my student petition. If you do not wish this form to be stored in your permanent file, please check here: \_\_\_\_\_.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY MEDICAL PROFESSIONAL:**

The student listed above is petitioning for special consideration regarding an FIU regulation. The student feels a medical problem may have directly or indirectly contributed to the need for such consideration. At the student's request, we would appreciate your cooperation in answering the following questions. Thank you for your assistance in this matter.

Health Care Provider's Name: \_\_\_\_\_

Health Care Provider's Type (Credentials): \_\_\_\_\_ License Number & State: \_\_\_\_\_

Health Care Provider's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

*Dates you treated this patient or family member:* \_\_\_\_\_

*In your opinion, was there a time period that the student was unable to attend class?* YES \_\_\_\_\_ NO \_\_\_\_\_

If yes: From \_\_\_\_\_ TO: \_\_\_\_\_

*Would this medical condition affect the student's ability to study or engage in class activities for periods of time?* YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, please explain:

*Would medication that you prescribed have interfered with the student's ability to complete coursework?* YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, please explain:

*In your opinion would it be medically necessary for the student to withdraw from all classes during the affected term(s)?* YES \_\_\_\_\_ NO \_\_\_\_\_

*In your opinion would it be medically necessary for the student to reduce his or her course load during the affected term(s)?* YES \_\_\_\_\_ NO \_\_\_\_\_

**Additional Comments:** (Please supply comments on letterhead if space is insufficient)

Health Care Provider's Signature: \_\_\_\_\_ Date \_\_\_\_\_