INSTRUCTIONS: The lower part of this form should be completed by the appropriate medical professional.

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, please provide actual dates (MM/DD/YYYY): 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:

SUBMISSION INSTRUCTIONS

1) Submit form along with your Student Petition to a OneStop Enrollment Coordinator in:
   MMC, SASC Building, 1st Floor; Phone: 305-348-7000
   BBC, AC1 100; Phone: 305-348-7000

Rev.18
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 ____________________________

SUBMISSION INSTRUCTIONS

1) Submit form along with your Student Petition to a OneStop Enrollment Coordinator in:
   MMC, SASC Building, 1st Floor; Phone: 305-348-7000
   BBC, AC1 100; Phone: 305-348-7000