STUDENT PETITION

MEDICAL SUPPORT FORM

INSTRUCTIONS: If you have selected Medical as the reason for your student petition, you must submit this form completed by your health care provider, with the appropriate signature and stamp. Incomplete forms will not be accepted.

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.

____________________________   ______________________
Student’s Signature                            Date

TO BE COMPLETED BY HEALTH CARE PROVIDER:

The student listed above is petitioning for removal of grades or courses at FIU. The student feels a medical condition may have directly or indirectly affected their academic progress. 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: _________________________________  Health Care Provider’s Office Stamp or Business Card

Specific 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 specific 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:

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 (Select One: withdraw from all classes/ reduce their course load) during the affected term(s)? YES _____ NO _____

Additional Comments: (Please supply additional information on health care provider’s letterhead if space is insufficient)

Health Care Provider’s Signature: ____________________________________________ Date ____________________________

SUBMISSION INSTRUCTIONS

1) Login to your my.fiu.edu account
2) Click on Upload My Documents
3) Select REGISTRATION from the drop-down menu
4) Select STUDENT PETITION from the drop-down menu
5) Submit

Rev April 2020