FIU FLORIDA INTERNATIONAL UNIVERSITY
Enrollment Management & Services

Student Petition Medical Support Form

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, 1401 S.W. 108 Ave, Modesto Maidique Campus, SASC Building 1st Floor, 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 ____________________________________