FLORIDA GULF COAST UNIVERSITY

STUDENT ENGAGEMENT

Healthcare Provider Verification Form

Student: *Please complete this section of the form before providing it to your Healthcare Provider.* By signing below, you authorize your Healthcare Provider to disclose any information about you and your medical records which are needed to complete all sections of this form. You also authorize your provider to provide any additional documentation (such as test results, provider notes, appointment dates and times, or any other documents) to support your request for a Withdrawal for Extenuating Circumstances and any other related appeals you may request (Fee Appeal, Financial Aid Appeal, etc.). This information will be used only for the purposes of the appeals you have selected, and will be subject to the protections of the Family Education Rights and Privacy Act.

Student's Name_____ Date of Birth: ____/____/____

University ID#: _____ Term(s) of Requested Withdrawal:_____

Name of Provider: _____

Student Signature: _____

Provider: The information you provide will assist Florida Gulf Coast University in making a determination in this appeal. The student listed above is requesting that the university modify their official transcript and/or their financial liability for courses they are currently, or were previously, enrolled in, based on an extenuating medical or psychological injury or illness. In general, such illness or injury must be outside the control of the student, must be new or newly discovered, or must have changed in some way, which the student would not reasonably have expected during the semester in question.

Provider Address: _____

Telephone: _____ Fax: _____

Type of Practice/Medical Specialty: _____

What is/was the student's medical diagnosis or what is the student being treated for:

_____

Date(s) you treated the student: _____

_____

Is treatment of this illness or injury on-going at this time?: **Yes** **No**

Was the student hospitalized?: **Yes** **No**

Date(s) of Admission: _____

Was the student referred to other health care provider(s) for evaluation or treatment? **Yes** **No**

If yes, please state the purpose of the referral: _____

_____

Would any medications prescribed interfere with academic performance? **Yes** **No** **N/A**

Would this condition prevent the student from completing some or all coursework?: **Yes** **No**

Please describe any specific limitations the student may experience (such as extended periods of standing or sitting, limitations on using specialized tools, instruments or equipment, etc.):

_____

_____

Describe other relevant medical facts, if any, related to the condition for which the student seeks a withdrawal for extenuating circumstances. (This may include future treatments, symptoms the student may or may have experienced, specialized equipment the student may need, or restrictions imposed.)

_____

_____

_____

_____

_____

_____

Please return the completed form to the student or submit directly the university.

Printed Provider Name: _____

Signature: _____

License#: _____ Or include your office stamp in the space below.

Date: ____/____/____

Fax: 239-590-7903
E-Mail: CourseWithdrawal@fgcu.edu
Address: Student Care Services
Withdrawal Committee
10501 FGCU Blvd.
South Ft. Myers, FL
33965-6565