



## Health Care Provider Verification Form

To be completed by licensed Health Care Provider

### STUDENT/PATIENT INFORMATION:

Name: \_\_\_\_\_

Banner ID: \_\_\_\_\_

DOB: \_\_\_\_\_

Term and Year of Appeal: \_\_\_\_\_

### CONSENT TO RELEASE MEDICAL INFORMATION

I, \_\_\_\_\_, give my permission for my Health Care Provider to release information to the University of Memphis concerning my condition as it relates to my request for a refund and/or credit of registration fees.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

### INSTRUCTIONS TO THE HEALTH CARE PROVIDER:

In order to consider an exception to the University's established refund policy for medical situations, the University of Memphis requires documentation from a licensed Health Care Provider to verify that the student listed above is unable to attend the University of Memphis during the specified semester, based on the existence of a current, non-pre-existing condition. Please complete the following information:

Description of Student/Patient's condition and how it prevents the student from attending the University. (Attach additional sheets as necessary.)

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Date of First Visit: \_\_\_\_\_

Date you last examined the student/patient: \_\_\_\_\_

I certify that, in my professional opinion, \_\_\_\_\_ is/was unable to attend the University of Memphis during the specified term due to the medical conditions described above.

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Health Care Provider

\_\_\_\_\_  
Phone Number of Health Care Provider