INSTRUCTIONS FOR PHYSICIAN

This form is to be used to help the student with documentation for an exception to the University of Minnesota’s refund policy. When completing this form, you will be asked to rate conditions on a scale of mild, moderate, or severe. Please use these ratings to indicate the usual state of severity of the conditions during the illness period. Mild is intended to indicate impairment in functioning greater than would be expected for a college/university student, leading to some impairment in studying and/or missing of classes. Moderate indicates further impairment in functioning that is not excessive or extreme. Severe indicates extreme difficulty in functioning and complete inability to attend class or study. If additional space is needed, attach a separate letter on letterhead providing further information.

STUDENT NAME

<table>
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<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Student ID</th>
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To be completed by physician/medical professional

Patient was seen for medical condition on (list all dates): ________________________________

List your diagnosis: ________________________________________________________________

Length of treatment: ______________________________________________________________

Was the student physically/emotionally incapable of attending classes during the term of illness?  □ Yes  □ No

Rate the severity of how the illness impacted the student’s daily functioning during the term of the illness?

- □ Mild (less than 2 weeks)  □ Moderate (2-6 weeks)  □ Severe (more than 6 weeks)

List specific symptoms and how they prevented the student from attending class(es) ________________________________________________________________

Extent of the illness or injury as it relates to the student’s ability to participate in class:

- □ Hospitalization (including day hospitalization) required (from ______________________ to ______________________)
- □ Confined to bed (from ______________________ to ______________________)

Rate how the student’s illness affected the following daily functions:

- Ability to concentrate □ Mild □ Moderate □ Severe □ Not applicable
- Ability to sleep □ Mild □ Moderate □ Severe □ Not applicable
- Ability to attend class or study □ Mild □ Moderate □ Severe □ Not applicable
- Energy level □ Mild □ Moderate □ Severe □ Not applicable
- Other ______________________ □ Mild □ Moderate □ Severe □ Not applicable

Did you recommend ongoing treatment/therapy?  □ Yes  □ No

If yes, how often is/was the required treatment? □ Daily □ Weekly □ Monthly □ Other ______________________

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<td>If yes, how often is/was the required treatment? □ Daily □ Weekly □ Monthly □ Other ______________________</td>
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When do you believe the student can/could resume daily activities, including attending class(es)?

__________________________________________________________________________

Other comments pertinent to the student’s circumstances:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

SERVICE PROVIDER SIGNATURE

By signing below, you are certifying that the information you provided is true to the best of your knowledge.

Name ____________________________ Title ________________ Date ________________

Signature ____________________________

Name of service provider ____________________________ Phone ____________________________

STUDENT SIGNATURE

Signature of student authorizing release of medical information.

Signature ____________________________ Date ____________________________