# Medical Form

**Undergraduate Academic Regulations Committee (ARC)**

UNIVERSITY of SOUTH FLORIDA

Student Success

Office of the Registrar

**INSTRUCTIONS**

Part II of this form needs to be completed in its **entirety** by the appropriate medical professional, including the provider's signature. Students should include this medical form with their complete petition packet.

**PART I. TO BE COMPLETED BY THE STUDENT**

Student's Name ____________________________________ USF ID ____________________ Relevant Time Period______________

Affected Semester (s) ______________________ Medical problem pertains to: ☐ Student ☐ Family Member

I am requesting (name of healthcare provider) _______________________________ to release the information requested below to the Universit of South Florida Academic Regulations Committee for the purpose of supporting my ARC petition. If you do not wish this form to be stored in your permanent file, please check here ☐

**Student's Signature** ________________________________________________________ **Date** __________________________________

**PART II. TO BE COMPLETED BY HEALTH CARE PROVIDER**

The student listed above is petitioning the Academic Regulations Committee of the University of South Florida for special consideration regarding a USF 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.

Provider's Name ____________________________________________ License Number & State ________________________________

Provider's Address ___________________________________________________________ Phone _______________________________

***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 (Date) ______________________ To (Date) _____________________

***Would length of class be pertinent to the student's ability to attend?*** (i.e. student could attend a 1 hour class, but not a 3 hour lab)

YES _____ NO ______ If Yes, please explain __________________________________________________________________________

***Would this medical condition affect the student's ability to study or engage in class activities for periods of time?*** (i.e. labs, field experiences, or phsical activity)

YES ______ NO ______ If Yes, please explain __________________________________________________________________________

***Would medications prescribed interfere in any way with the student's performance?***

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** ________________