ST. CLOUD STATE UNIVERSITY
720 4th AVENUE SOUTH
ST. CLOUD, MINNESOTA 56301-4498

Student: If you cited medical or psychological issues as reasons for an academic appeal or other academic change, it is necessary to have your medical/psychological provider verify the extenuating circumstances that are cited in your request. It is not necessary to supply full medical records. The provider information on this form must be returned with your appeal or academic change request.

MEDICAL VERIFICATION FORM

FOR ACADEMIC APPEALS AND REQUESTS FOR ACADEMIC CHANGE

SCSU ID# or SSN: _____ Email: _____@stcloudstate.edu

_____ _____ _____
First Name Middle Name Last Name

COURSE(S) IMPACTED BY MEDICAL/PSYCHOLOGICAL CONDITION (list individual courses):

☐ **Entire Semester: Term _____ Year _____**

	ID: Ex 000243	**Course Title**	**Dept** Ex ENGL	**Number** 191	**Sec** 01	**Credits** 4	**Term** SPRING	**Year** 2014
1								
2								
3								
4								

Return to (student check department):

☐ Academic Appeals & Probation
St. Cloud State University, CH210
720 4th Avenue South
St. Cloud, MN 56301-4498
Fax: (320) 308-5672
Email: aap@stcloudstate.edu

☐ Business Services
St. Cloud State University, AS123
720 4th Avenue South
St. Cloud, MN 56301-4498
Email: businessservices@stcloudstate.edu

☐ Office of Records and Registration
St. Cloud State University, AS118
720 4th Avenue South
St. Cloud, MN 56301-4498
Fax: (320) 308-2059
Email: registrar@stcloudstate.edu

☐ **Other:** Office _____
St. Cloud State University, _____
720 4th Avenue South
St. Cloud, MN 56301-4498
Fax: (320) 308- _____
Email: _____@stcloudstate.edu

Please sign and date this form which acknowledges that you give permission to your medical/psychological provider to furnish the required information below.

Student Signature: _____ Date: _____

PROVIDER: The student named above is requesting documentation for extenuating circumstances that have impacted their academic performance. The nature of the request and the permission to release information are at the top of this form. Please respond on your letterhead or fill out form on opposite side and attach business card. Return to office address indicated by student. Thank you.

Student's First Name	Student's Middle Name	Student's Last Name	Last 4 SSN
_____	_____	_____	_____

Provider Name: _____

Contact information: (Attach card or include letterhead) _____

Provider Signature: _____ Date: _____

This St. Cloud State University student is asking to withdraw from one or more classes or appeal an academic issue because of a medical/psychological condition for which you have treated them.

Please fill out the following portion of this form in its entirety to assist the student in the withdrawal process.

Medical/psychological condition (brief description-Submission of medical records not required):

_____

_____

_____

_____

_____

_____

Date of onset of condition: _____ Duration of condition:_____

Dates of visits for this condition: _____

- In your professional opinion would the above condition for which you have treated the student prevent a student from attending class sessions in a University setting? Yes ____ No ____
- Please identify the dates or duration for which attendance may be impacted: _____
- In your professional opinion would the above condition for which you have treated the student prevent completion of coursework in a University setting for the above time periods? Yes ____ No ____
- Please identify the dates or duration for which coursework may be impacted: _____
- In your professional opinion has treatment progressed to the point where resumption of coursework and attendance is a reasonable expectation for the student? Yes_____ No _____