THE COLLEGE OF
ARTS + SCIENCES

College Graduate Office
Owen Hall
812.856.3687
collgrad@indiana.edu

Graduate Student Leave of Absence Medical Certification

This section to be completed by the Graduate Student:

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Last | First | Student ID #

____________________ **Circle one of the following if you are on a:** ____________________

Degree Program | Fellowship | Student Academic Appointment | Date Leave Will Begin/End

Medical Reason for Leave: ____

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By signing below, you authorize the health care provider to release the following medical information for the purpose of determining compliance with the College of Arts and Sciences Graduate Student Leave of Absence guidelines.

Student Signature: ______________________________________ Date:____________________

This section to be completed by the Health Care Provider:

Patient's Name: ____

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Printed Name of Health Care Provider | Signature of Health Care Provider

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Type of Practice | Phone Number | Address

Condition for which the patient is being treated: ______________________________

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Please submit completed medical certification form to:
College Graduate Office, Owen Hall, 790 E. Kirkwood Avenue, Bloomington IN 47405
Fax: 812.855.2060/Email: collgrad@indiana.edu