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:**

______________________________________________________________

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: ______________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

*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: ______________________________________________________

______________________________________________________________

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

______________________________________________________________

Type of Practice | Phone Number | Address

Condition for which the patient is being treated: ______________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

***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***