Graduate Student Parental Accommodation Medical Certification

******************* This section to be completed by the Graduate Student *******************

Last Name
First Name
Student ID #

Degree Program
Estimated Dates of Accommodation

Reason for Requested Accommodation: ____________________________________________

___________________________________________________________________________

___________________________________________________________________________

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

Student Signature: __________________________ Date: _______________________

****************** This section to be completed by the Health Care Provider ******************

Patient’s Name: __________________________

By signing below you attest to the accuracy of the information provided above

Printed Name of Health Care Provider
Signature of Health Care Provider

Type of Practice
Phone Number
Address