THE COLLEGE OF
ARTS + SCIENCES

College Graduate Office
Owen Hall
812.856.3687
collgrad@indiana.edu

Graduate Student Parental Accommodation Medical Certification

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

Last _____ First _____ 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 _____

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