

**MEDICAL DOCUMENTATION FORM**  
**OHIO UNIVERSITY**  
**University Appeals Committee**

NOTE: This form is to be completed by the student's physician or mental health practitioner, stapled to a one-page letter, and returned to the student to be submitted **by the student** with the appeal:

Clinician Name \_\_\_\_\_ Student Name \_\_\_\_\_

Licensed As \_\_\_\_\_ Student PID # \_\_\_\_\_

License # \_\_\_\_\_ State of Licensure \_\_\_\_\_

Clinician Address \_\_\_\_\_

Clinician Phone \_\_\_\_\_ Date of Most Recent Visit \_\_\_\_\_

Clinician Fax \_\_\_\_\_ Total Number of Visits \_\_\_\_\_  
(Within the last 3 months)

Please provide your professional judgment regarding the student named above.

To consider tuition adjustments based on a medical withdrawal, we need appropriate medical documentation. **Please provide a one-page letter describing the medical/psychological condition of the student.** You should include information about the initial on-set of the condition, type, frequency and severity of symptoms, treatments or medications necessary to alleviate symptoms, and the medical necessity behind the withdrawal. *We are particularly interested in whether this medical/psychological condition prevented or adversely impacted this student from remaining in classes.* **Please staple your letter to this form and return it to the student to be included with the appeal.**

In addition, please answer the following questions below:

1. What date did this student first seek treatment? \_\_\_\_\_

2. Does this student's condition/treatment require that she/he medically withdraw from the university?  
\_\_\_\_\_ No \_\_\_\_\_ Yes If yes, what date? \_\_\_\_\_

3. Is the student medically able to return to the University? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Physician/Mental Health Provider's Signature

\_\_\_\_\_  
Date