### Academic Record Adjustment/Request for Refund

**Medical/Clinical Verification Form**

#### STUDENT INFORMATION (To be filled out by the student)

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Semester(s) and Year(s) You are Petitioning For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student A Number:</td>
<td>(If only petitioning specific courses, please list):</td>
</tr>
</tbody>
</table>

I hereby permit this release of medical information from my licensed care provider to Utah State University.

Student’s Signature: __________________________________________

☐ I certify that all signatures are authentic and free of forgery. I understand that forging a signature or providing false information can lead to disciplinary action.

#### PHYSICIAN’S VERIFICATION (To be filled out by the physician)

Date(s) student was under your care: ____________________________

If not under your care during the semester in question, were you able to review past records in order to provide this information?  ☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>Office Location:</th>
<th>Office Phone:</th>
</tr>
</thead>
</table>

Brief description of illness/injury/condition:

- __________________________________________________________________________
- __________________________________________________________________________
- __________________________________________________________________________
- __________________________________________________________________________

1. Did the student’s illness/condition/procedure inhibit him/her from attending classes?

   ☐ Yes  ☐ No

2. Based on his/her condition, how many weeks of school during the semester in question would you expect the student to be absent from class?

   ☐ Less than two weeks  ☐ Two weeks or more

Any additional comments/recommendations (You may attach a separate explanation on letterhead in addition to this form if desired):

- __________________________________________________________________________
- __________________________________________________________________________

Licensed Care Provider’s Printed Name: (Include post-nominals): __________________________________________

Licensed Care Provider’s Signature: ___________________________________________

Date: ___________________________

☐ I certify the above information to be true and correct to the best of my knowledge.

Please submit this verification form back to the student to return to our office or fax to 435-797-1110 (Attn: ARA Committee) or mail to 1600 Old Main Hill Logan, UT 84322-1600 Attn: ARA Committee. Thank you.