

Medical Leave Provider Attestation

**Student instructions:**

Please fill out the top portion of the form, submit it to your health care provider for his/her signature.

**Provider instructions:**

Please fill out and sign the form and then fax to the Student Health & Wellness Center at (503)494-2958

## STUDENT SECTION

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, (Student Name-Please Print) hereby authorize the health care provider below to release the information indicated below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date



## PROVIDER SECTION

HEALTH CARE PROVIDER PRINTED NAME:

HEALTH CARE PROVIDER TITLE:

HEALTH CARE PROVIDER LICENSE #:

PROVIDER EMAIL: PROVIDER PHONE:

I attest that the OHSU student named above is in my care and that this student has a health condition that requires the student named above to take a leave of absence from their current OHSU academic program based on the OHSU Technical Standards listed here:

<https://ohsu.ellucid.com/documents/view/20895/?security=3392ffe2df4bea8df4758b49f17a54e9a02ceb47>

* My best estimate of the length of leave required is: (a length of time less than or equal to one calendar year).
* I cannot estimate the length of leave required at this time. I anticipate being able to make and estimate on .

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature Date