

Health Care Provider Reinstatement Attestation

**Student instructions:**

Please fill out the top portion of the form, submit it to your health care provider for their 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 Printed 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



## HEALTH CARE 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:

As of the date below, the student named above is capable of meeting the technical standards to be an OHSU student as outlined in the link below.

[Https://ohsu.ellucid.com/documents/view/20895/?Security=3392ffe2df4bea8df4758b49f17a54e9a02ceb47](https://ohsu.ellucid.com/documents/view/20895/?security=3392ffe2df4bea8df4758b49f17a54e9a02ceb47)

*(If this link is not working, please contact Student Health and Wellness at shw@ohsu.edu).*

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Provider Signature Date