The purpose of this form is to certify that the student is fit to return to school/work if a serious health condition required that medical leave be granted.

This section to be completed by the student:

Name of Student: ___________________________  Univ ID# __________________
Department: _______________________________  Days Absent: ______________

This section to be completed by the health care provider:

Yes  No  Is student able to return to class and to perform the essential functions of student’s position in their Graduate program? If “NO,” when will the student be able to perform the essential functions? ____________________________

Comments or limitations suggested:

______________________________
______________________________
______________________________

Health Care Provider Information:

Name: ___________________________
Signature: ________________________  Medical Specialty or
Type of Practice: __________________
Date: ____________________________