COLLEGE of CHARLESTON
GRADUATE SCHOOL
UNIVERSITY OF CHARLESTON, S.C.

MEDICAL DOCUMENTATION FORM

This section to be completed by the student.

1. _____ _____
   CWID Degree or Certificate Program

2. _____ _____ _____
   Last Name First Name Middle Name

3. _____ _____ - _____ - _____
   College of Charleston Email Phone Number

4. Select One:

_____ Appeal academic dismissal - student must also submit formal appeal

_____ Petition for Late Withdrawal from Course(s) - student must also submit *Petition for Late Withdrawal* form

_____ Request for Leave of Absence - student must also submit *Request for Leave of Absence* form

_____ Request Extension of Program Time Limit - student must also submit formal request for extension

_____ Request Extension of Incomplete Grade - student must also submit C*ourse Completion Agreement* form

5. Term(s) Corresponding to Appeal, Petition, or Request (TERM/YEAR): _____

I request the release of medical information from the provider listed below to the Graduate School at the University of Charleston, S.C. at the College of Charleston. I understand that the information included in this form will be considered by the Graduate School when determining my request. I understand that, if applicable, the Graduate School may consult with campus professionals in Student Health Services, Counseling Center, the Center for Disability Services, and/or the Dean of Students Office when considering the information contained in this form. I understand this form may be shared with the Dean of Students Office to determine if any additional stipulations may be appropriate.

Student Signature: _____ Date: _____

Contact:

Randolph Hall, Suite 310
The Graduate School
College of Charleston
66 George Street
Charleston, SC 29424-0001

Email: gradstud@cofc.edu
Phone: 843.953.5614
Fax: 843.953.1434

The remainder of this form to be completed by the treatment provider.

INSTRUCTIONS TO THE TREATMENT PROVIDER

The student (patient/client) named above is a current student of the College of Charleston who is appealing, petitioning, or requesting an extension (see above). The College of Charleston requires documentation from a treating health care provider who can attest that the student is experiencing a condition that is significantly impacting the student's ability to meet the essential elements of their academic program. The College will weigh your opinion when considering the student's demonstrated need and the corresponding appeal, petition, or request. College officials may also refer back to this information at the time that the student seeks to re-enroll at the College of Charleston in order to assess whether or not there has been a sufficient improvement in the condition that prompted the leave, late withdrawal, extension, etc.

Provider/Clinician Name:

Credentials of provider:

Description of student's illness or condition:	Date of most recent appointment pertinent to appeal, petition, or request:
Date of diagnosis:	Total # of appointments pertinent to appeal, petition, or request:

Please provide information regarding student's **symptoms** (include comments on **duration, frequency and changes in intensity** during the semester in question) and how these symptoms are impacting the student's ability to function at the College of Charleston.

☐ Yes ☐ No ☐ N/A	Did the student's condition significantly impact the student's ability to function academically in one or more classes and/or terms? **If Yes, please describe:**
☐ Yes ☐ No ☐ N/A	Did the student's condition significantly impact the student's ability to function safely or autonomously without supervision in an academic environment? **If Yes, please describe:**

In your opinion, **does the student's condition justify their appeal, petition, or request?**
☐ Yes
☐ No
☐ Not enough data to render an opinion based on patient interaction

Comments:

In your opinion, **does the student need a specific type of care to be successful in their academic program?**
☐ Yes
☐ No
☐ Not enough data to render an opinion based on patient interaction

If Yes, please describe:

ATTESTATION BY COMMUNITY PROVIDER

By signing where indicated below, I am representing to the College of Charleston that my response to each question listed above is true, complete, and accurate to the best of my knowledge and belief, that it constitutes my best professional judgment and opinion, and that the student/patient/client did not prepare or draft that response for my signature.

Legal Signature: x _____ (L.S.) Date: _____

Printed Name and Professional Credentials: _____

Address: _____

_____

Phone: _____ Fax: _____ Email: _____

Please use additional pages or attach additional documentation if you wish to expand on your responses to the questions above and/or to record any other comments or observations you may wish to make regarding the student's appeal, petition, or request.