Salem | STATE UNIVERSITY

Health Care Provider Verification Form

INSTRUCTIONS TO THE STUDENT

You are expected to submit the Health Care Provider Verification form when you request to discontinue an in-progress course or request a refund **due to medical reasons**.

Submit a completed and signed copy of this form by **one** of the following methods:

- **Upload** this form when you submit a request at any of the pages linked below:
  - Request to Withdraw for the semester or Take a Leave of Absence,
  - Request a Refund Appeal, or
  - Request a Withdrawal from your program
- **or Email** the form to the School of Graduate Studies (graduate@salemstate.edu)
- **or Fax** the form to us at 978.542.7215.

Be sure to fill in the **Student** identification fields and **Patient** "consent to release" fields on the following page. Then, bring or send this form to your health care provider to complete the rest.

You only need to submit Page 2.

Completion of this form does not guarantee a refund. The Refund Appeals Committee reviews all materials submitted and makes a recommendation for approval or denial of appeals.

Return form to: School of Graduate Studies
Sullivan Building 113
352 Lafayette Street
Salem, MA 01970
graduate@salemstate.edu
FAX 978.542.7215

Salem State University

Health Care Provider Verification Form

Name of Patient _____
(Last) (First) (Middle)

Name of Student, if different _____ Student ID# _____
(Last) (First) (Middle)

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

In order to consider a petition for a waiver of tuition forfeiture fees, Salem State University requires documentation from a licensed health care provider verifying a current condition that prevents the student from attending the university during this semester. Please provide the following information along with a signed piece of letterhead after the student/patient has completed the release consent at the bottom of this form.

Description of patient's condition and how it prevents patient/student from attending the university.
(Attach additional sheets as necessary)

_____

_____

_____

_____

_____

When did you last examine the patient? _____

I certify that, in my professional opinion, the above named student is currently unable to attend Salem State University during the _____ (semester) of _____ (year) due to the medical conditions described above.

Signature of Health Care Provider _____ Date_____

Health Care Provider's name printed _____

Health Care Provider license information (State, Type, Number) _____

Health Care Provider's phone number _____

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____ , give my permission for my health care provider to release information to Salem State University concerning my physical condition as it relates to a request for a waiver of tuition forfeiture fees.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian (if Patient is under the age of 18) Date

A medical withdrawal or refund appeal for medical reasons requires this form. Completion of this form does not guarantee a refund. The Refund Appeals Committee reviews all materials submitted and makes a recommendation for approval or denial of appeals.