Medical Documentation Form (To Be Completed if Citing a Medical Issue)

The required information is necessary for the continuous legitimate business and educational operation of Eastern Michigan University. It is, and will be, maintained in compliance with applicable US law, educational accrediting body requirements, and institutional policies and procedures. Questions or concerns may be directed to Reinstatement_Requests@emich.edu

EID #	Name

Medical Information to be completed by provider

Instructions for medical/mental health provider: The student listed above has requested an academic exception from Eastern Michigan University due to a medical/mental health condition. Please provide detail about the impact of their medical or mental health condition for the indicated semester. In order to constitute a serious medical condition, a student must have been or will be unable to perform academically (attend class, study course content, take tests, write papers) for an extended period of time.

Brief summary of illness/condition:_____

_____

_____

Date of original diagnosis and most recent dates of treatment for this condition:_____

Is the condition considered (circle one): Chronic Episodic Acute

Was student hospitalized for this condition? If so, please provide dates. _____

What impact has the condition had on the student's academic performance and successful completion of the semester?

_____

_____

_____

_____

_____

_____

Does this condition have the ability to potentially impact this student's academic performance and successful completion of future semesters they register for? (circle one) Yes No

If yes, please articulate potential challenges to help us in identifying student support services and an academic success plan suited to their needs should their reinstatement request be approved: _____

Certification

The Academic Status Review Committee at Eastern Michigan University may contact the provider by telephone to verify any of the information that has been provided within this document.

_____ _____

Provider Signature Printed Name of Provider

- ☐ Physician/Medical Professional (e.g. MD, DO) **or**
- ☐ Fully Licensed Mental Health Professional (e.g. Psychologist, Social Worker, Licensed Counselor)

_____ _____

Address Date

_____ _____

City, State, Zip Phone