LEARNING ABROAD CENTER

UNIVERSITY OF MINNESOTA

REFUND APPEAL MEDICAL SUPPLEMENT

INSTRUCTIONS FOR PHYSICIAN

This form is to be used to help the student with documentation for an exception to the University of Minnesota's refund policy. When completing this form, you will be asked to rate conditions on a scale of mild, moderate, or severe. Please use these ratings to indicate the usual state of severity of the conditions during the illness period. Mild is intended to indicate impairment in functioning greater than would be expected for a college/university student, leading to some impairment in studying and/or missing of classes. Moderate indicates further impairment in functioning that is not excessive or extreme. Severe indicates extreme difficulty in functioning and complete inability to attend class or study. If additional space is needed, attach a separate letter on letterhead providing further information.

Student Name

Last _____ First _____ Middle _____ Student ID _____

To be completed by physician/medical professional

Patient was seen for medical condition on (list all dates): _____

List your diagnosis: _____

_____

_____

Length of treatment: _____

Was the student physically/emotionally incapable of attending classes during the term of illness? ☐ Yes ☐ No

Rate the severity of how the illness impacted the student's daily functioning during the term of the illness?

☐ Mild (less than 2 weeks) ☐ Moderate (2-6 weeks) ☐ Severe (more than 6 weeks)

List specific symptoms and how they prevented the student from attending class(es) _____

_____

_____

_____

Extent of the illness or injury as it relates to the student's ability to participate in class:

☐ Hospitalization (including day hospitalization) required (from _____ to _____)

☐ Confined to bed (from _____ to _____)

Rate how the student's illness affected the following daily functions:

Ability to concentrate	☐ Mild	☐ Moderate	☐ Severe	☐ Not applicable
Ability to sleep	☐ Mild	☐ Moderate	☐ Severe	☐ Not applicable
Ability to attend class or study	☐ Mild	☐ Moderate	☐ Severe	☐ Not applicable
Energy level	☐ Mild	☐ Moderate	☐ Severe	☐ Not applicable
Other _____	☐ Mild	☐ Moderate	☐ Severe	☐ Not applicable

Did you recommend ongoing treatment/therapy? ☐ Yes ☐ No

If yes, how often is/was the required treatment? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

Over for more

When do you believe the student can/could resume daily activities, including attending class(es)? _____

_____

Other comments pertinent to the student's circumstances: _____

_____

_____

_____

Service Provider Signature

By signing below, you are certifying that the information you provided is true to the best of your knowledge.

Name _____ Title _____ Date _____

Signature _____

Name of service provider _____ Phone _____

Student Signature

Signature of student authorizing release of medical information.

Signature _____ Date _____

LEARNING ABROAD CENTER

230 Heller Hall, 271 19th Avenue South, Minneapolis, MN *55455*

612.626.9000 888.700.UOFM | 612.626.8009 (fax) | UMabroad@umn.edu | **UMabroad.umn.edu**