

# MEDICAL DOCUMENTATION FOR APPLICATION FOR TUITION CREDIT

**STUDENT COMPLETES:**

\_\_\_\_\_  
Student's Name (Last) (First) (Middle)

\_\_\_\_\_  
Address (Street) (City) (State) (Zip)

\_\_\_\_\_  
Student ID # or Social Security Number (last 4 digits) Phone Number

*We understand that information about you and your health is personal and confidential. Any medical information submitted for the evaluation of your Application for Tuition Credit for Medical Reasons will be used by the College's Health and Wellness Center and appropriate College officials for this purpose only. These medical records will not be released to anyone without your express written permission, except where required by law.*

*(handwritten signature only)*  
\_\_\_\_\_  
Student Signature Date

\*\*\*\*\*  
**PHYSICIAN COMPLETES:**

To the Physician: Your patient has applied for a tuition credit due to a sudden medical emergency. Please complete the information below so that we can determine his/her eligibility for this credit.

Please advise the specifics of diagnosis and treatment plan. Was this patient hospitalized for this condition?

\_\_\_\_\_  
\_\_\_\_\_

What is the length of time the patient has been under your care for this condition? \_\_\_\_\_

Please advise the reason why you feel this patient is unable to complete classes this semester.

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Name (please print) Phone Number

\_\_\_\_\_  
Address (Street) (City) (State) (Zip)

\_\_\_\_\_  
Physician Signature Date