

Medical/Mental Health Verification Form

For Student Record Adjustment and Refund Requests

GENERAL INFORMATION

Students seeking a record adjustment or refund for medical or mental health reasons must submit this form to their medical or mental health provider for completion. This form is used to verify the authenticity and severity of the circumstances presented. If petitioning due to an immediate family member's circumstance, the family member's provider must complete this form. Completing this form does not guarantee approval.

STUDENT INFORMATION AND RELEASE

To be completed by the student.

UVID: _____ Name: _____ Semester: _____ Courses: All Some

I authorize the release of my medical records/information to Utah Valley University to provide details relevant to my request. In accordance with the Family Educational Rights and Privacy Act (FERPA), I also authorize the Utah Valley University Registrar's Office to share my grades and class schedule information with my medical/mental health provider (named below) as needed to accurately evaluate my request.

➔ **Student Signature:** _____ **Date:** _____

MEDICAL OR MENTAL HEALTH PROVIDER VERIFICATION

To be completed by the medical or mental health provider. Specific justification for each semester affected is required.

Date(s) individual was under your care: _____ Semester(s) Affected: _____

Nature of medical or mental health condition/illness/injury/event (brief description): _____

In your professional opinion, do you believe this condition/illness/injury/event significantly impaired the student's ability to successfully complete schoolwork and courses?

Yes No

If the individual is submitting this request for only **some** of the courses in the semester (see above), please explain how the medical event, condition, etc. was incapacitating for some courses and not the whole semester.

MEDICAL OR MENTAL HEALTH PROVIDER INFORMATION AND SIGNATURE

The UVU Registrar's Office may contact you to confirm that the information provided on this form is not fraudulent or altered in any way, or to obtain additional clarification regarding the request.

Printed Name (and post-nominals): _____ License #: _____

Name of Practice/Clinic: _____

Email (if available): _____ Phone: _____

➔ **Signature:** _____ **Date:** _____