Supplementary Documentation
PSYCHOLOGICAL/MEDICAL DOCUMENTATION FORM

UNIVERSITY OF OREGON ▫
OFFICE OF THE REGISTRAR
registrar@uoregon.edu

NOTE: This Psychological/Medical Documentation Form must be completed by attending physician (if physical health concern) or psychologic/psychiatric clinician (if psychological health concern) and cannot be completed by a family member. We do **NOT ACCEPT OR CONSIDER ANY NON-REQUESTED DOCUMENTATION** (insurance forms, bills, explanations of benefits (EOB) forms, hospital records, or medical records etc.). If a petition is approved based on the medical circumstance stated below, an adjustment is granted only once. Should the same condition reoccur or persist in future terms, no further appeal for refunds will be allowed as you are aware of the condition, and should manage your course registration accordingly.

SECTION 1: STUDENT IDENTIFICATION (completed by student)

Student Name _____ UO ID No. _____

Student Signature* _____ Date _____

**Signature of student authorizes release of medical information to the UO Office of the Registrar*

SECTION 2: PHYSICIAN'S CERTIFICATION (must be completed by attending physician only, then faxed directly from physician's office to 541-346-6682, ATTN: Petition Support)

Clinician Name _____ Licensed As _____

License No _____ State of Licensure _____

Clinician Address _____

Clinician Phone No. _____ Clinician Fax No. _____

Date of student's most recent visit _____ Total visits (within the last 3 months) _____

1. Please provide the medical/psychological diagnosis:

2. Initial date of onset of the condition: _____

3. Degree and Dates of Incapacitation: (enter durations of all extents of incapacitation):

DEGREE OF INCAPACITATION		DATES	
SEVERE	Completely incapacitated as regards to functioning at an academic level (unable to attend class)	**FROM** _____	**TO** _____
MODERATE	Able to fulfill some academic obligations, but performance was considerably affected (unable to attend some class)	**FROM** _____	**TO** _____
SLIGHT	Able to fulfill academic obligations, but performance was likely affected (able to attend class)	**FROM** _____	**TO** _____
NEGLIGIBLE	No significant effect on ability to fulfill academic obligations	**FROM** _____	**TO** _____

☐ **Unable to comment due to lack of information**

4. Treatments or medications necessary to alleviate student:

5. The symptoms of illness and/or side effects of medication (i.e., drowsiness, insomnia, lack of concentration, loss of memory, pain, none, etc.):

*Signature _____ Date _____

Attending Physician/Mental Health Professional