# Medical/Clinical Verification Form

<table>
<thead>
<tr>
<th>Full Name (Last, First Middle)</th>
<th>BYU ID #</th>
<th>Semester/Term/Year</th>
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I authorize the release of my medical records to the university in order to provide information relevant to my petition.

Student signature: _____________________________

Date(s) student was under your care: ________________ Location of care: ___________________

Nature of illness or injury (diagnosis and progress):

1. How many school days were/will be missed as a result of the student’s illness/injury/disorder?
   - ☐ 1-3 days  ☐ 4-8 days  ☐ 9-13 days  ☐ 14+ days  ☐ Undetermined

2. To what degree did the illness/injury/disorder impact the student’s ability to study?
   - ☐ Significant  ☐ Moderate  ☐ Low  ☐ Not at all  ☐ Undetermined

3. To what degree did the illness/injury/disorder impact the student’s ability to make reasonable decisions?
   - ☐ Significant  ☐ Moderate  ☐ Low  ☐ Not at all  ☐ Undetermined

4. Expected time frame the student to be affected by the illness/injury/disorder?
   - ☐ 1-3 days  ☐ 4-8 days  ☐ 9-13 days  ☐ 14+ days  ☐ Undetermined

5. To what degree were you able to assess the student’s illness/injury/disorder?
   - ☐ Significant  ☐ Moderate  ☐ Low  ☐ Not at all  ☐ Undetermined

Were there other factors contributing to the student’s inability to perform at his/her best? Please explain.

Additional Comments (You may attach a separate statement, if desired.) _________________________

Specific recommendations/accommodations:

- ☐ Decrease credit hours to ______
- ☐ Withdraw from classes for semester

- ☐ Leniency with absences
- ☐ Extended time to complete assignments

- ☐ Extended time to complete tests
- ☐ Distraction-free environment for taking tests

Medical/Clinical Professional’s Printed Name: ___________________________ License #: ____________

Medical/Clinical Professional’s Signature: ___________________________ Date: ________________