

TUITION REFUND COMMITTEE PSYCHOLOGICAL/MEDICAL DOCUMENTATION FORM

UNIVERSITY OF OREGON □
OFFICE OF ACADEMIC ADVISING
101 OREGON HALL □ EUGENE OR 97403
P 541-346-3211 □ F 541-346-6048

NOTE: This Psychological/Medical Documentation Form must be completed by attending physician (if physical health concern) or psycholog/psychiatric clinician (if psychological health concern) and cannot be completed by a family member. The committee does **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, a refund 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 you 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 Tuition Refund Committee*

SECTION 2: PHYSICIAN'S CERTIFICATION (must be completed by attending physician only, then faxed directly from physician's office to 541-346-6048, ATTN: Tuition Refund Committee)

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

Updated: December 12, 2017