**Healthcare Provider Verification of Medical Condition Form**

This form serves as documentation of medical/health issues in support of a student request

(e.g., for a leave of absence, a clinical site placement exemption, or to return from a leave of absence).

**Student Instructions**

Complete Section I before giving this form to your healthcare provider. Once signed by your provider, upload this form to the appropriate Oasis academic history field with your request. A completed form must accompany any request citing medical grounds submitted by a student.

**Healthcare Provider Instructions**

The student listed in Section I is filing a request with the Robert Larner, M.D. College of Medicine at The University of Vermont on the basis of health reasons. The Larner College of Medicine does not wish to know any specifics of the medical condition, only whether, in your best judgement, the student’s ability to participate in a rigorous curriculum is likely to be critically affected by their condition.

**Section I. For Completion by the STUDENT**

**Student Name**: Click here to enter text.  **Contact Information:** Click here to enter text.

**Type of Request: Specify Dates:** Click here to enter text.

[ ]  Leave of Absence

[ ]  Local Clinical Site Preference

[ ]  Return from Health-Related Leave of Absence

*I authorize the healthcare provider named below to complete this form and provide the information requested by the Robert Larner, M.D. College of Medicine at The University of Vermont.*

**Student or Patient Signature: Date:**  Click here to enter a date.

**Section II. For Completion by the HEALTHCARE PROVIDER**

Please respond to the questions below that correspond with the type of request indicated by the student above. Your response and completion of this section of the health care provider form indicates that you are a qualified health care provider and have been treating this student for the condition that requires this request.

*Requests for clinical site exemption*

* Is the condition both significant and necessitating ongoing local treatment such that the student must remain at UVMMC for their clinical rotations during the indicated time period? [ ]  Yes [ ]  No
* Please provide specific need for remaining local (e.g. frequency of appointments, therapy that cannot be completed elsewhere): Click here to enter text.
* Estimated period of time that you anticipate the student will not be able to participate in their medical education curriculum at affiliate sites: Click here to enter text.

*Requests for leave absence*

* Is the condition significant enough to prevent the student from successfully participating in the curriculum during the indicated time period? [ ]  Yes [ ]  No
* Estimated period of time that you anticipate the student will not be able to participate in their medical education curriculum: Click here to enter text.

*Requests to return from a health-related leave of absence*

* Is the student ready to return to and fully reengage with the curriculum? [ ]  Yes [ ]  No

**Additional Provider Notes (optional):**  Click here to enter text.

**Name of Healthcare Provider (include professional credential):** Click here to enter text.

**Contact Information:** Click here to enter text.

**Signature: Date:** Click here to enter a date.