MEDICAL VERIFICATION FORM
FOR REGISTRATION APPEAL

Registration Help Center/Accessibility Resources
132 Wigley Adm. Bldg. Mankato, MN 56001

507-389-2252
507-389-5719 FAX

If a physical or mental health condition contributed to your inability to complete course(s), your healthcare professional should verify the extenuating circumstances explained in your registration appeal.

MEDICAL RECORDS ARE NOT REQUIRED IF THIS FORM IS COMPLETE WHEN SUBMITTED

Student Section:

Student Name: ____

Star or Tech ID: ___________________________________

Student email address: ____

Semester(s) impacted by condition being documented:

Fall 20______ Spring 20______ Summer 20______

I hereby authorize my Healthcare professional to document/verify my condition for this situation.

Student Signature: ____ **Date:** ____________

Medical Personnel Section: (The medical provider must complete this section)

The student named above is requesting documentation of a physical or mental health issue which may have impacted her/his academic performance.

Provider Name: ____

Provider contact information: ____

Physical/mental health condition (brief description; attach additional pages if needed):

____

Date of onset of condition: _______________________ Duration of condition: ____________________

In your opinion, did the issue impede the student's ability to attend class? Yes ______ No ______

Please list the dates when attendance may have been impacted: ______________________________

Did the condition impede the student's ability to complete coursework? Yes______ No _______

Please list the dates when coursework may have been impacted: _____________________________

Provider Signature: ____ Date: ________________