ACADEMIC REGULATIONS COMMITTEE MEDICAL FORM

INSTRUCTIONS

The lower part of this form needs to be completed by the appropriate medical professional and the entire form should be returned ***in a SEALED ENVELOPE from the physician's office, with his/her name, address, and telephone number inscribed***, along with your completed petition, to the appropriate ARC representative at the University of South Florida, 4202 East Fowler Avenue, Tampa, FL 33620.

PART 1. TO BE COMPLETED BY THE STUDENT:

Student's Name: _____U number: _**U**_____ Relevant time Period: _____

Affected Semester (s): _____ Medical problem pertains to: _____ Student _____ Family Member (Check One)

I am requesting Dr. _____ to release the information requested below to the University of South Florida Academic Regulations Committee for the purpose of supporting my ARC petition. I do not wish this form to be stored in your permanent file, please check here: .

_____ _____
(Student's Signature) (Date)

PART 2. TO BE COMPLETED BY PHYSICIAN:

The student listed above is petitioning the Academic Regulations Committee of the University of South Florida for special consideration regarding a USF regulation. The student feels a medical problem may have directly or indirectly contributed to the need for such consideration. At the student's request, we would appreciate your cooperation in answering the following questions.
Thank you for your assistance in this matter.

Physician's Name: _____ License Number & State:_____

Physician's Address: _____

***Dates you treated this patient or family member as related to this request*:**_____

In your opinion, was there a time period that the student was unable to attend class? ___YES ___ NO

If yes: From_____ To:_____
(Date) (Date)

Would length of class be pertinent to the student's ability to attend*?* (i.e. student could attend a one hour class, but not a three hour lab)

YES___ NO___ If Yes, please explain:

Would this medical condition affect the student's ability to study or engage in class activities for periods of time? (i.e. labs, field experiences, or physical activity)

YES___ NO___ If Yes, please explain:

Would medications prescribed interfere in any way with the student's performance?

YES___ NO___ If Yes, please explain:

In your opinion would it be medically necessary for the student to withdraw from <u>all classes</u> during the affected term(s)? YES___ NO___

In your opinion, would it be medically necessary for the student to reduce his or her course load during the affected term(s)? YES___NO___

Additional Comments: (Please supply comments on letterhead if space is insufficient)

Physician's Signature: _____ **DATE: _____/_____/_____**

INCOMPLETE PETITIONS WILL NOT BE PROCESSED