

**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: _____