

Licensed Provider Recommendation for Return to Campus (Medical Clearance)

Part I: Provider Information Please complete all formation required.

ProviderName:	PracticePhone:
Practice Address:	

Provider Credentials (please select): MD/DO,Specialty: NursePractitioner,Specialty:

Mental Health Professional, pleasecify:

Part III: Clinical History Please completell information required in detail. Additional information may be provided on your office letterhead.

Patient's Diagnoses with ICID and/or DSM code\$Attach additional sheets if needed

Describe how the condition(s) has/have resolved or stabilized so that it is not likely to interfere with the patient's academic performance, safety or weeting upon return to the University of North Alabama:

Provide the date of resolution or stabilizationatevel no longer interfering with the patient's academic performance, safety or welbeing upon return to the University divorthAlabama:

Please provide the date(s) the patient was under your catedsediagnoses:

If ongoing care is needed to maintain resolution or stabilization of the patient's condition, describe the plan of care, including medication, ongoing therapy and follow.

Part IV: Certification Statement

With my signature below, I provide my recommendation for platient's return to camputer the term or semester 20_____, at the University of North Alabama. The patient has given me permission to share the foregoing information with University bloch Alabama officials and discuss their medical information with a physician or representative thereof, at the University of North Alabama.

Physician Signature:		Date:	
Signature (CM, DSS, UH	IS)	Date:	