Provider Certification for Medical Absence

University of Missouri-Kansas City School of Medicine Allied Health Programs

Student Name: ______________________________ Student ID: ______________

Year/Semester: __________ Program: ______________

My signature below authorizes my care provider to complete and submit this form, the attached Technical Standards document, and the letter indicated to the UMKC Office of Council on Evaluation.

Student Signature:______________________________ Date:__________

Provider Directions: Please review the attached Technical Standards document and then complete this form and letter as indicated for the student/patient listed above. Completed forms (including the Technical Standards form) must be submitted to the UMKC School of Medicine's Council on Evaluation. Forms may be faxed with a coversheet to 816-235-6613 or scanned and emailed to Mr. Connor Fender at fenderco@umkc.edu. Please contact the Council on Evaluation at 816-235-2171 with questions.

Provider Information

Provider's Name: ______________ Type of Practice/Medical Specialty: ______________

Address: ______________ Phone: ______________

______________ Fax: ______________

____

Medical Facts

Approximate date condition commenced: ______________

Was the student admitted for an overnight stay in a hospital or residential medical care facility? _____ No _____ Yes

If yes, please provide dates of admission: ______________

Date of medical provider's assessment of student: ______________

Will you continue to provide ongoing care for this student? _____ No _____ Yes

Estimate the beginning and ending dates of medical leave for this student: Begin: __________ End: __________

By attached letter, please describe the necessity of medical leave for this student (i.e. ongoing physical visits, medical therapy, etc.).

Provider Certification

By signature below, the provider certifies the following:

1. I am not an emergency department or urgent care provider for the student/patient at this time.
2. I am the treating provider for this student during a medical leave of absence.
3. I am not related to this student in any way.
4. I reviewed the Technical Standards and believe the student/patient is unable to comply with them at this time.
5. I saw and evaluated this student in person and recommended a medical leave of absence.

______________________________ ______________________________

Provider Signature Provider Name

Please fax (with coversheet) or scan the completed form with attached letter and the Technical Standards document directly to Mr. Connor Fender in the UMKC School of Medicine Council on Evaluation at 816-235-6613 or fenderco@umkc.edu.

PROVIDER CERTIFICATION FOR RETURN FROM MEDICAL ABSENCE

UNIVERSITY OF MISSOURI-KANSAS CITY SCHOOL OF MEDICINE ALLIED HEALTH PROGRAMS

Student Name:____ Student ID: __________________

Year/Level: __________ Unit: ____________________

My signature below authorizes my care provider to complete and submit this form and the attached Technical Standards document to the UMKC Office of Council on Evaluation.

Student Signature:______________________________________ Date:_________________

Provider Directions: Please review the attached Technical Standards document and then complete this form and letter as indicated for the student/patient listed above. Completed forms (including the Technical Standards form) must be submitted to the UMKC School of Medicine's Council on Evaluation. Forms may be faxed with a coversheet to 816-235-6613 or scanned and emailed to Mr. Connor Fender at fenderco@umkc.edu. Please contact the Council on Evaluation at 816-235-2171 with questions.

Provider Information

Provider's Name: ____________________ Type of Practice/Medical Specialty: ____________________

Address: ______________________________________ Phone: ______________________

______________________________________ Fax: ______________________

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Medical Facts

Approximate date condition commenced: _________________________

Date of medical provider's most recent assessment of student/patient: ___________

Will you continue to provide ongoing care for this student/patient? ____ No ____ Yes

Recommended end date of leave for this student/patient: ________________________

Provider Certification

By signature below, the provider certifies the following:

1. I was the treating provider for this student/patient during a medical leave of absence.
3. I am not related to this student/patient in any way.
4. I reviewed the Technical Standards and believe the student/patient is able to comply with them.
5. I saw and evaluated this student/patient in person and recommend a return to full participation as a student in medical school.

___________________________________ ___________________________________

Provider Signature Provider Name

Please fax (with coversheet) or scan the completed form and Technical Standards document to Mr. Connor Fender in the UMKC School of Medicine Council on Evaluation at 816-235-6613 or fenderco@umkc.edu.