Provider Certification for Family and Medical Leave

UMKC School of Medicine

Student Name ____ Student ID: ____________________________

My signature below authorizes my care provider to complete and submit this form to the UMKC Council on Evaluation

Student/Patient Signature ____

Provider Directions: Please review the UMKC School of Medicine Technical Standards document provided by the student/patient and then complete this form as indicated for the student/patient listed above. Review of the Technical Standards is not required for a patient that is not a student at the UMKC School of Medicine Completed forms can be returned directly to the student/patient or submitted directly to the UMKC School of Medicine's Council on Evaluation. Forms may be emailed to Connor Fender at fenderco@umkc.edu. Please contact the Council on Evaluation at 816.235.2171 with questions.

Provider Name ____ Medical Specialty ____________________________

Address: ____ Phone _____________________________

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Approximate date condition commenced______________

Date of provider's assessment of student/patient _________________________________

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

Recommended end date of of Family and Medical leave for this student _________________

By signature below, the provider certifies the following:

- I was the treating provider for this student/patient during a Family and Medical leave of absence.
- I am not related to this patient in any way.
- I, if applicable, reviewed the UMKC School of Medicine Technical Standards and believe the student is unable to comply with them at this time.
- I saw and evaluated the student/patient in person or via Telehealth and recommend a return to full participation as a student in medical school.

_____________________________________ _____________________________________

Provider Signature Provider Name