

Licensed Provider Recommendation for Return to Campus (Medical Clearance)

Part I: Provider Information Please complete aillformation required. ProviderName: PracticePhone: Practice Address: Provider Credentials (please select): MD/DO,Specialty:_____ NursePractitioner,Specialty: Mental Health Professional, pleasacity: 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 codesAttach additional sheets if needed Describe howhe condition(s) has/have resolved or stabilized so that it is not likely to interfere with the patient's academic performance, safety or wastling upon return to the University of North Alabama: Provide the date of resolution or stabilizationateevel no longer interfering with the patient's academic performance, safety or wellbeing upon return tolte University dNorthAlabama: Please provide the date(s) the patient was under your cathefsediagnoses: 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 follows Part IV: Certification Statement With my signature below, I provide my recommendation for patient'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 Morth 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, UHS) Date: