

# MEDICAL SUPPLEMENT

**DIRECTIONS**—This form assists students in providing documentation of a medical or disability condition when petitioning for an exception to a University of Minnesota policy. You must complete the Academic Policy Petition (<https://z.umn.edu/APPetition>), 13-credit Exemption Request ([z.umn.edu/CreditExemptionRequest](https://z.umn.edu/CreditExemptionRequest)), and/or Tuition Refund Appeal ([z.umn.edu/TuitionRefundAppeal](https://z.umn.edu/TuitionRefundAppeal)) along with this Medical Supplement form. The form is best completed by a physical or mental health care/medical provider. In some circumstances, the Disability Resource Center (DRC) may complete this form if you are currently registered with and have provided current health/medical documentation to your access consultant. If additional space is needed, please attach a separate letter on letter-head. The intent of this form is to specify dates and impact of medical or disability condition.

The University reserves the right to verify the authenticity of any information provided on this form.

To ensure privacy online, open in Adobe Reader (free at Adobe.com). Please add the required signature(s) in blue or black ink.

<b>PART A. Student information</b>			
Student name (last, first, middle initial)	University ID		
<b>Signature of student authorizing release of medical information required</b>			
Student signature	Date		
<b>PART B. Medical information</b>			
Completed by physical or mental health care/medical professional <input type="checkbox"/> or by the DRC access consultant (check one) <input type="checkbox"/>			
Physical or mental health care/medical professional or the DRC access consultant met or had contact with the student on (list all dates, including date registered if completed by the DRC):			
Is this medical condition/disability a continuation of a previous condition? <span style="float: right;"><input type="checkbox"/> yes <input type="checkbox"/> no</span>			
If yes, (check all that apply)			
Is this a chronic condition? <span style="float: right;"><input type="checkbox"/> yes <input type="checkbox"/> no</span>			
Did the student experience a relapse? <span style="float: right;"><input type="checkbox"/> yes <input type="checkbox"/> no</span>			
Did the student experience complications? <span style="float: right;"><input type="checkbox"/> yes <input type="checkbox"/> no</span>			
Did a change in medication or treatment affect the student's ability to attend class? <span style="float: right;"><input type="checkbox"/> yes <input type="checkbox"/> no</span>			
<b>The duration of the condition or treatment that impacts/impacted the student's ability to participate in class because of the following:</b>			
<input type="checkbox"/> hospitalization (including day hospitalization) required (from _____ to _____)			
<input type="checkbox"/> confined to bed (from _____ to _____)			
<b>The duration/symptoms of the condition or treatment that impacts/impacted the student's daily functions:</b>			
Beginning date of condition and/or treatment: _____			
Ending or anticipated ending of condition and/or treatment: _____			
When do you believe the student can/could resume daily activities, including attending class(es)?			
List specific symptom(s) and how they prevented the student from attending and participating in class(es)?			
<b>Did the student's condition and/or treatment affect the following daily functions:</b>			
<b>Condition and/or treatment</b>	<b>Yes</b>	<b>No</b>	
Ability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	Ability to study
Ability to sleep	<input type="checkbox"/>	<input type="checkbox"/>	Low energy level
Ability to attend class	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Difficulty interacting with others	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Other comments pertinent to the student's circumstances:			
<b>PART C. Certification</b>			
Name/title	Date		
Signature	Name of service office/hospital/clinic	Phone number	

