UNIVERSITY OF MINNESOTA

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 (z.umn.edu/AcademicPolicyPetition), 13-credit Exemption Request (z.umn.edu/CreditExemptionRequest), and/or Tuition Refund Appeal (z.umn.edu/TuitionRefundAppeal) along with this Medical Supplement form. This form must be completed by the medical provider or by the Disability Resource Center if the student is currently registered with and has provided medical documentation surrounding their condition to the Disability Resource Center. If additional space is needed, please attach a separate letter on letterhead. 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.

PART A. Student information

Student name (last, first, middle initial)	University ID

Signature of student authorizing release of medical information required

Student signature	Date

PART B. Medical information

Completed by ☐ physician/medical professional or ☐ the Disability Resource Center *(check one)*

Physician/medical professional or the Disability Resource Center met or had contact with the student on (list all dates):

Is this medical condition/disability a continuation of a previous condition? ☐ yes ☐ no

If yes, (check all that apply)

- Is this a chronic condition? ☐ yes ☐ no
- Did the student experience a relapse? ☐ yes ☐ no
- Did the student experience complications? ☐ yes ☐ no
- Did a change in medication or treatment affect the student's ability to attend class? ☐ yes ☐ no

The duration of the condition or treatment that impacts/impacted the student's ability to participate in class because of the following:

☐ hospitalization (including day hospitalization) required (from _____ to _____)

☐ confined to bed (from _____ to _____)

The duration/symptoms of the condition or treatment that impacts/impacted the student's daily functions:

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)?

Did the student's condition and/or treatment affect the following daily functions:

Condition and/or treatment	Yes	No		Condition and/or treatment	Yes	No
Ability to concentrate	☐	☐		Ability to study	☐	☐
Ability to sleep	☐	☐		Low energy level	☐	☐
Ability to attend class	☐	☐		Other: _____	☐	☐
Difficulty interacting with others	☐	☐		Other: _____	☐	☐

Other comments pertinent to the student's circumstances:

PART C. Certification

Name/title		Date
Signature	Name of service provider/hospital/clinic	Phone number

For assistance with this form, call the Disability Resource Center at 612-626-1333. The University of Minnesota is an equal opportunity employer and educator.
This form is printed on paper made from no less than 20 percent post-consumer waste.
OTR174 9/19

Please recycle