Updated 09/2018

Saint Louis University
Academic Records Revision Medical Certification Form

Form #41

Section 1 Student

Student/Patient Name _____ **Student ID** _____ **Student Email** _____

By signing this form, I am authorizing my medical record/information be released to Saint Louis University in support of my request for a revision of my academic record.

Student Signature _____ **Date** _____

Section 2 Symptoms/Diagnosis

To the physician: Before an academic record revision will be considered, students must provide verification that they were under a physician's care for a condition which prevented them from performing academic duties. Please list the student's symptoms/diagnosis:

The above symptoms/diagnosis affected: (check all affected areas of performance)

- ☐ Class attendance
- ☐ Homework Assignments
- ☐ Long-term projects
- ☐ Other (please describe below)

Other: _____

Section 3 Verification

I verify that from _____ to _____, this patient was unable to perform their academic duties due to medical reasons.

Physician's Signature _____ **Physician's Printed Name** _____ **Date** _____

Physician's Address (street, city, state, zip code) _____

Form Procedures

1. Student completes section 1.
2. Physician completes section 2 and 3 and stamp form (if applicable).
3. Physician sends directly to physical or electronic address listed below.

Physician Office Stamp

Office of Academic Affairs - DuBourg Hall, Room 422
One Grand Blvd. St. Louis MO 63103 arrc@slu.edu