

Health Care Provider Verification Form

OFFICE OF THE REGISTRAR, UW1-160 (425) 352-5240 FAX (425) 352-5455

<p>INSTRUCTIONS TO THE HEALTH CARE PROVIDER:</p> <p>In order to consider a petition for a waiver of tuition forfeiture fees, the University of Washington Bothell requires documentation from a licensed Health Care Provider verifying a current condition that prevents the student from attending the University during this quarter. Please provide the following information along with a business card or piece of letterhead after the student/patient has completed the release consent at the bottom of this form.</p> <p>RETURN THIS FORM TO:</p> <p>University of Washington Bothell</p> <p>Office of the Registrar 18115 Campus Way NE Campus Box 358500 Bothell, WA 98011</p>	Name of Student/Patient	
	Patient's Student Number	
	Description of Student/Patient's condition and how it prevents the student from attending the University. <i>(Attach additional sheets as necessary)</i>	
	Date of first visit	When did you last examine the student?
	<p>I certify that, in my professional opinion, _____ is currently unable to attend the University of Washington Bothell during _____ (quarter) of _____ (year) due to the medical conditions described above.</p> <p>Signature of Health Care Provider: _____</p> <p>Health Care Provider's name printed: _____</p> <p>Date: _____ Health Care Provider's phone number: _____</p>	

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____, give my permission for my Health Care Provider to release information to the University of Washington Bothell concerning my physical condition as it relates to my request for a waiver of tuition forfeiture fees.

Signature of Student

Date

Signature of parent or guardian (if student is under the age of 18)

Date