UNIVERSITY of WASHINGTON
UW STUDY ABROAD

HEALTH CARE PROVIDER VERIFICATION FORM

Return to: UW Study Abroad
University of Washington
459 Schmitz Hall, P.O. Box 355815
Seattle, WA 98195-5815

Phone: 206.221.4404
Fax: 206.685.3511
Email: studyabroad@uw.edu

INSTRUCTIONS FOR HEALTH CARE PROVIDER

The student named below is submitting a petition for Emergency Withdrawal from a UW Study Abroad Program. In order to consider an Emergency Withdrawal Petition, the University of Washington, Seattle, requires documentation from a licensed Health Care Provider verifying a medical condition that prevents the student from participating in the UW Study Abroad Program. Please provide the following information after the student/patient has completed the consent to release medical information below.

Name of Student/Patient *(Last)* *(First)* *(Middle)*		
Name of Patient (if not student) *(Last)* *(First)* *(M.I.)*		Relationship to Student
Date of first visit?	When did you last examine the Student/Patient?	
Description of Student/Patient's condition and how it prevents the student from participating in the chosen study abroad program. *(Attach additional sheets as necessary.*		

CONSENT TO RELEASE MEDICAL INFORMATION

I, *(Student/Patient)*_____ **give my permission for my Health Care Provider to release information to the University of Washington, Seattle, concerning my physical condition as it relates to this request for Emergency Withdrawal.**

Signature of Student_____ Date

Signature of Patient (if not student)_____ Date

Signature of Parent or Guardian (if student/patient is under the age of 18)_____ Date

CERTIFICATION

I certify that in my professional opinion, *(Student Name)*_____**is unable to participate in a UW Study Abroad Program, during** *(Quarter)*_____ **of** *(Year)*_____ **due to the medical conditions described above.**

Signature of Health Care Provider_____ Date_____.

Name of Health Care Provider *(PRINT NAME)*	Phone Number of Health Care Provider - -