

**AUTHORIZED ABSENCE FORM /  
MEDICAL DOCUMENTATION FOR ACADEMIC STANDING FORM**  
(to be completed and signed by student)

Students must supply all required information before their request is considered. Please print.

NAME: \_\_\_\_\_

STUDENT NO.: \_\_\_\_\_ PROGRAM NO.: \_\_\_\_\_

EMAIL: \_\_\_\_\_ TEL. NO.: \_\_\_\_\_

<input type="checkbox"/> Authorized absence request for the following courses <input type="checkbox"/> Medical documentation for academic standing request for the following courses				
Semester & Year:		<input type="checkbox"/> Fall _____	<input type="checkbox"/> Winter _____	<input type="checkbox"/> Summer _____
<u>Course &amp; Section No.</u>	<u>Course Name</u>	<u>Course &amp; Section No</u>	<u>Course Name</u>	
√ <u>Ex. 603-102-MQ-03</u>	<u>English</u>	<u>Ex. 603-102-MQ-03</u>	<u>English</u>	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

Date illness/incapacity began \_\_\_\_\_ Length of illness/incapacity \_\_\_\_\_

Reason for request for absence:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The deadline for this request is the grade deadline for the semester in question. If request is being made **after this deadline** please explain the reason:

\_\_\_\_\_

\_\_\_\_\_

***I swear that all the information provided is true and accurate. I authorize the Registrar's Office, if necessary, to contact the healthcare provider for purposes of confirming and/or clarifying the authenticity and content of the information provided for this request.***

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FOR AUTHORIZED ABSENCES, IF GRANTED, THE NOTATION "IN" WILL APPEAR ON YOUR TRANSCRIPT FOR ALL THE APPROVED COURSES.

**FOR OFFICE USE ONLY**

**Decision:**

- Permanent Incomplete for all the above courses
- Permanent Incomplete granted for courses marked above with Registrar's initials
- Permanent Incomplete denied, reason \_\_\_\_\_

**Additional requirements:**

- Dr's note req'd to return
- 2<sup>nd</sup> Request
- Refer to Academic Advising
- Refer to AccessAbility

Registrar's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL REPORT

(to be completed and signed ONLY by healthcare provider)

Patient's Name: \_\_\_\_\_

This is to certify that the above-named patient was seen on the following date(s):

\_\_\_\_\_

The patient was/is unable to attend/participate in classes

from \_\_\_\_\_  
DD/MM/YY

to \_\_\_\_\_  
DD/MM/YY

Please check if end date is unknown but incapacity is for a period of at least 3 consecutive weeks.

as a result of the following diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Degree of inability to attend/participate in classes:  all courses

partial, specify which course(s):

\_\_\_\_\_

Student may resume regular studies as of: \_\_\_\_\_  
DD/MM/YY

Notes: (you may use this space to provide any other pertinent information, including prognosis)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name (please print):		
License number:		
Street address:		
City		Postal code:
Telephone Number:		Fax Number:
Signature:		
Date:		