CHARLESTON SOUTHERN UNIVERSITY

HEALTH CARE PROVIDER VERIFICATION FORM

INSTRUCTIONS TO THE HEALTH CARE PROVIDER:	Name of Student/Patient:	Student Number:
In order to consider a tuition appeal petition, Charleston Southern University requires documentation from a licensed Health Care Provider verifying a current condition that prevents the student from attending the University during this semester. 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.	I certify that the above was in my care for medical treatment from _____to_____. The nature of the patient's illness/injury is detailed below:	
	DIAGNOSIS:	
	TREATMENT:	
	REASON PATIENT IS UNABLE TO ATTEND CLASS:	
Return this Form to: Charleston Southern University Student Accounts Office 9200 University Blvd PO Box 118087 Charleston, SC 29423 *fax:* 843-863-8074 *Email:* studentaccounts@csuniv.edu	I affirm the patient's illness/injury required special care provided by _____(Physician Name) and in my opinion necessitated the student's withdrawal. Signature:_____ Date: _____ Phone Number: _____	

CONSENT TO RELEASE MEDICAL INFORMATION:

I, _____, give my permission for my Health Care Provider to release information to Charleston Southern University concerning my physical condition as it relates to my request for a tuition appeal petition.

_____ _____

Signature of Patient Date

_____ _____

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