CHARLESTON SOUTHERN UNIVERSITY

HEALTH CARE PROVIDER VERIFICATION FORM

<table>
<tr><td rowspan="6">INSTRUCTIONS TO THE HEALTH CARE PROVIDER:
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 <u>Business Card or Documentation on Letterhead completed by the Physician. Appeal will not be accepted without the listed above.</u> Student/patient must complete the release consent at the bottom of this form.
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</td><td>Name of Student/Patient:</td><td>Student Number:</td></tr>
<tr><td colspan="2">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:</td></tr>
<tr><td colspan="2">DIAGNOSIS:</td></tr>
<tr><td colspan="2">TREATMENT:</td></tr>
<tr><td colspan="2">REASON PATIENT IS UNABLE TO ATTEND CLASS:</td></tr>
<tr><td colspan="2">I affirm the patient's illness/injury required special care provided by _________________________________(Physician Name) and in my opinion necessitated the student's withdrawal.

Signature of Physician:____
Date: _______________ Phone Number: ___________________</td></tr>
<tr><td colspan="3">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
Medical appeals will be reviewed within 30 days of submission.</td></tr>
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