FITCHBURG STATE UNIVERSITY

HEALTH CARE PROVIDER VERIFICATION

Return form to: Director of Student Accounts/ Fitchburg State University Attn: Tuition Appeals / 160 Pearl Street, Fitchburg, MA 01420 / Fax: 978-665-3559

I, _____ , give my permission for my Health Care Provider to release information to Fitchburg State University concerning my condition as it relates to my request for a waiver of tuition and fees.

Signature of Student _____ Date _____

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

Completion of this form does not guarantee a refund. The Tuition Appeals Committee reviews all materials submitted and makes a recommendation for approval or denial of appeals. The decision of the Tuition Appeals Committee is final.

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

In order to consider a petition for a waiver of tuition or fees due to medical reasons, Fitchburg State 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 signed piece of letterhead after the student/patient has completed the release consent at the top of this form.

Name of Student Patient: _____
(Last) *(First)* *(Middle)*

Patient's Student ID #: _____

Describe Student/Patient's condition and how it prevents the student from attending the university. *(Attach additional sheets as necessary)*

_____

_____

_____

_____

Date of first visit: _____ When did you last examine the student? _____

I certify that, in my professional opinion, the above named student is currently unable to attend Fitchburg State University during the

of _ due to the conditions described above.
(semester) *(year)*

Health Care Provider's Signature _____

Health Care Provider's Name Printed _____

Date _____ Health Care Provider's Phone Number _____