

**INSTRUCTIONS:** If you have selected Medical as the reason for your student petition, you must submit this form completed by your health care provider, with the appropriate signature and stamp. Incomplete forms will not be accepted.

**TO BE COMPLETED BY THE STUDENT:**

Student's Name: \_\_\_\_\_ Panther ID: \_\_\_\_\_

Relevant time Period: \_\_\_\_\_ Affected Semester(s) \_\_\_\_\_

Medical problem pertains to: \_\_\_\_\_ Student \_\_\_\_\_ Immediate Family Member (please circle one: grandparent, parent, sibling, spouse, or child) **Must provide written support from their primary health care provider, social worker, or case manager as the primary caregiver.**

I am requesting Dr. \_\_\_\_\_ to release the information requested below to Florida International University for the purpose of supporting my student petition.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY HEALTH CARE PROVIDER:**

The student listed above is petitioning for removal of grades or courses at FIU. The student feels a medical condition may have directly or indirectly affected their academic progress. At the student's request, we would appreciate your cooperation in answering the following questions. Thank you for your assistance in this matter.

Health Care Provider's Name: \_\_\_\_\_

Health Care Provider's Type (Credentials): \_\_\_\_\_

License Number & State: \_\_\_\_\_

Health Care Provider's Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Specific dates you treated this patient or family member:** \_\_\_\_\_

Health Care Provider's Office  
Stamp or Business Card

**In your opinion, was there a time period that the student was unable to attend class?** YES \_\_\_ NO \_\_\_

If yes, please provide specific dates (MM/DD/YYYY): From \_\_\_\_\_ TO: \_\_\_\_\_

**Would this medical condition affect the student's ability to study or engage in class activities for periods of time?**

YES \_\_\_ NO \_\_\_ If YES, please explain:

**Would medication that you prescribed have interfered with the student's ability to complete coursework?** YES \_\_\_ NO \_\_\_

If YES, please explain:

**In your opinion would it be medically necessary for the student to (Select One: withdraw from all classes/ reduce their course load) during the affected term(s)?** YES \_\_\_ NO \_\_\_

**Additional Comments:** (Please supply additional information on health care provider's letterhead if space is insufficient)

Health Care Provider's Signature: \_\_\_\_\_ Date \_\_\_\_\_

**SUBMISSION INSTRUCTIONS**

- 1) Login to your my.fiu.edu account
- 2) Click on Upload My Documents
- 3) Select REGISTRATION from the drop-down menu
- 4) Select STUDENT PETITION from the drop-down menu
- 5) Submit