**Northern Illinois University
Medical Appeal Provider Verification Form**

Graduate students who wish to withdraw for medical reasons are required to fully complete and submit pages 2 -3 of this document.

1. The student must complete the Student Application and Authorization (page 2).
2. A licensed attending physician, Advanced Practice Provider (APN) or Certified

Physician’s Assistant (PAC) must fully complete and sign the Licensed Provider Medical Documentation Form (page 3). The medical provider must submit the form directly to GradRecords@niu.edu. Forms sent by students will not be accepted.

1. This document or information form will not be disclosed to anyone outside of our department without authorization for the Release of Information signed by the student.
2. We will review the submitted information. This review is typically completed in approximately 5 working days after the fully completed and appropriately signed information is received.
3. If the medical information provided by the physician/provider is not sufficient, our office will notify the student of this determination. Additionally, new medical information may be submitted for review.
4. The falsification of any of these documents will be reported to the Office of Student Conduct for further action.

**I HEREBY REQUEST AND AUTHORIZE** the appropriate designees of Northern Illinois University, DeKalb, IL 60115:

To verify the presence of an acute and/or prolonged, severe medical condition during the above semester to be forwarded to the appropriate appeals committee (Graduate).

I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure and that my refusal to authorize disclosure of this information will result in the following consequences: Denial of my request.

I may revoke this authorization at any time by written notification to Northern Illinois University Graduate School. However, I understand revocation cannot be retroactive. I absolve and agree to hold harmless the individual or agency identified above, and the NIU Board of Trustees, together with its officers and employees, of any legal liability, claims or damages which may arise from the disclosure of this information. Unless revoked, this consent is valid until the request is completely processed.

Student name:

Z-ID:

Student signature:

Date:

Student’s Full Name: Z-ID#

Semester and Year of Request: DOB

Please type or print the requested information in the space provided below and return this form by email or mail to the address listed above.

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| --- | --- |
|  DIAGNOSIS AND ICD – 10 CODE of the severe medical condition impaired or obstructed the student’s class attendance and/or participation. |  |
| For the above condition, indicate the:* Date(s) of evaluation and treatment during the past 6 months
* Location of evaluation and treatments (e.g., office, hospital OP, hospital IP, etc.)
* Nature/ purpose of each evaluation and/or treatment provided
* Date of initial onset
 |  |
|  Provide the specific medical findings, restrictions and/or other objective data that documents how the student’s class attendance or participation was impaired or obstructed during the above semester(s) |  |

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Signature of Attending Physician, Advanced Practice Nurse or Physician’s Assistant - Certified

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Printed Name, Business Address, Telephone Number