Licensed Provider Recommendation for Return to Campus
(Medical Clearance)

Part I: Provider Information Please complete *all* information required.

Provider Name:_____ Practice Phone:_____
Practice Address: _____

Provider Credentials (please select):
MD/DO, Specialty: _____
Nurse Practitioner, Specialty: _____
Mental Health Professional, please specify: _____

NPI#:_____ License Number:_____ State of Issue: _____

Part II: Student Information

Patient's Full Name: _____
Patient's Date of Birth:_____ Patient's UNA L# (if known):_____

Part III: Clinical History Please complete *all* information required in detail. Additional information may be provided on your office letterhead.

Patient's Diagnoses with ICD-10 and/or DSM codes. (Attach additional sheets if needed.)

_____
_____
_____

Describe how the condition(s) has/have resolved or stabilized so that it is not likely to interfere with the patient's academic performance, safety or well-being upon return to the University of North Alabama: _____
_____
_____

Provide the date of resolution or stabilization to a level no longer interfering with the patient's academic performance, safety or well-being upon return to the University of North Alabama: _____

Please provide the date(s) the patient was under your care for these diagnoses:_____

If ongoing care is needed to maintain resolution or stabilization of the patient's condition, describe the plan of care, including medication, ongoing therapy and follow-up. _____
_____
_____

Part IV: Certification Statement

With my signature below, I provide my recommendation for the patient's return to campus for the_____ term or semester, 20____, at the University of North Alabama. The patient has given me permission to share the foregoing information with University of North Alabama officials and discuss their medical information with a physician, or representative thereof, at the University of North Alabama.

Physician Signature: _____ Date:_____

Signature (CM, DSS, UHS) _____ Date:_____