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:

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 at 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: _____