University of Kentucky

Office of the Univeristy Registrar
Phone: (859) 257-2031
Fax: (859) 257-7160

Medical Documentation Form for Tuition Appeal

This form is to be completed by both the student and the student's medical provider. The completed form must be **submitted by the medical provider** to the University of Kentucky Registrar's Office by fax to (859) 257-7160 or email to tuitionappeals@uky.edu.

Section 1 - Student Information (To Be Completed by Student)

*__Important__: Students must submit the Tuition Appeal application before completing this form. The Tuition Appeal application can be found at registrar.uky.edu/tuition-appeals.

Student Name: _____ **Student ID or DOB:** _____

Semester Appealing: _____ **Email Address:** _____

By signing below, I authorize my medical provider to disclose the information requested on this form to the University of Kentucky Tuition Appeals Committee for the purpose of reviewing my tuition appeal.

Student Signature: _____ **Date:** _____

Section 2 - Medical Information (To Be Completed by Medical Provider)

Name: _____ **License #:** _____

Licensed As: _____ **State of Licensure:** _____

Address: _____

Email Address: _____ **Phone Number:** _____

1. What date did the student first seek treatment? _____
2. Date of most recent visit: _____
3. Did the student's condition/treatment require them to withdraw from the University or reduce their course load during the semester listed in Section 1? ☐ Yes ☐ No (Please explain below)
4. Date the student became unable to perform academic duties: _____
   Academic duties include attending classes, studying course material, taking exams, and completing assignments.
5. Is the student medically able to return to academic study? ☐ Yes ☐ No (Please explain below)
6. Briefly describe how the student's medical condition affected their ability to perform the academic duties listed above and clarify any responses marked "No". If additional space is needed, please attach a separate sheet or letter.

_____

_____

_____

_____

_____

_____

Medical Provider's Signature: _____ **Date:** _____

***ATTN Medical Provider:** After completion, fax to (859) 257-7160 or email to tuitionappeals@uky.edu.