MEDICAL VERIFICATION FORM
FOR REINSTATEMENT WITH EXTENUATING CIRCUMSTANCES

Office of Academic Affairs
Minnesota State University, Mankato
315 Wigley Administration Center, Mankato, MN 56001

507-389-1333
507-389-5859 (Fax)

Student: If a physical or mental health issue contributed to your academic suspension, your healthcare professional should verify the extenuating circumstances explained in your reinstatement request.

Medical records are not required if this form is submitted.

Student Section: (The student submitting the appeal will complete this section)

Student Name: _____ Tech ID: _____

Student mavmail address: _____

Semester(s) impacted by condition being documented:

Fall_____ Spring _____ Summer _____; Fall_____ Spring _____ Summer _____

I hereby authorize my healthcare professional to document my case.

Student Signature: _____ Date: _____

Medical Personnel Section: (The medical provider will complete this section)

The student named above is requesting documentation of a physical or mental health issue which may have impacted her/his academic performance.

Provider Name: _____

Contact information: _____

Physical/mental health issue (brief description; attach additional pages if needed):

_____

_____

_____

Date of onset of issue: _____ Duration of issue:_____

In your opinion, did the issue impede the student's ability to attend class? Yes ☐ No ☐

Please list the dates when attendance may have been impacted: _____

In your opinion, did the issue impede the student's ability to complete coursework? Yes ☐ No ☐

Please list the dates when coursework may have been impacted: _____

In your professional opinion, has treatment progressed to the point where resumption of coursework and attendance is a reasonable expectation for the student? Yes ☐ No ☐

Provider Signature: _____ Date: _____