UNIVERSITY OF OREGON

CERTIFICATION OF HEALTH CONDITION BY LICENSED HEALTHCARE PRACTITIONER

Instructions: Print this form and have it completed by licensed healthcare practitioner. Include the completed form in the PDF that also includes your Application for an award through the Graduate Student Assistance Fund. THIS FORM MUST BE FILLED OUT COMPLETELY TO BE CONSIDERED.

1. Today's Date: _____

2. Student's First and Last Name: _____

3. Does the above-named student have a serious medical condition?

   ☐ YES ☐ NO

4. Does the above-named student have a spouse/partner, child or parent experiencing a serious medical condition?

   ☐ YES ☐ NO

5. Please describe the nature of the serious medical condition: _____

   _____

   _____

   _____

   _____

   _____

6. Date of condition onset or discovery: _____

7. Healthcare Provider Information

   Signature: _____

   Printed name: _____

   Date: _____

   Name of practice/firm: _____

   Address: _____

   Type of practice: _____

Form Revised 9/24/2021