# Provider Verification Form

UNIVERSITY of WISCONSIN GREEN BAY

Please complete the following information to assist the committee in determining appropriateness of the request. **Return the form to**: **Attn:** Enrollment Review Committee; via **Mail:** University of Wisconsin Green Bay, 2420 Nicolet Drive Green Bay, WI 54311; **Fax:** 920.465.2765**;** or **Email:** enrollmentservices@uwgb.edu

**STUDENT, PLEASE COMPLETE:**

ATTENTION:_____________________________________________
Name of health care provider

I have submitted a request to the UWGB Enrollment Review Committee for

☐ A late drop from the following course(s)_____________________________________________

_____________________________________ for the following semester_____________________

**OR**

☐ A late withdrawal from the following semester___________________________________________

I have indicated that a significant medical or mental health condition has affected my ability to continue with my coursework as

☐ I am being treated for: ______________________________________________________________

**OR**

☐ I am the caregiver of _________________________________ who is being treated for:

________________________________________________________________________________

________________________________________________________________________________

**Print Name** **Birthdate** **Signature** **Date Signed**

**MEDICAL PROVIDER, PLEASE COMPLETE:**

Approximate date condition(s) commenced:___________________________________

Please check the activities that are moderately or substantially impacted by the medical or mental health condition. Provide additional details describing how the situation affects the student in an academic setting, or how the patient's limitation influences the student as a caregiver.

| **Activity** | **Moderate** | **Substantial** | **Explain** |
|---|---|---|---|
| Keeping Appointments | | | |
| Stress Management | | | |
| Managing Internal Distractions | | | |
| Learning: | | | |
| • Reading | | | |
| • Writing/Spelling | | | |
| • Calculating | | | |
| • Listening | | | |
| • Thinking | | | |
| • Concentrating | | | |
| • Memorizing | | | |
| Mobility | | | |
| Other: | | | |
| Other: | | | |

________________________________________________________________________________

**Print Provider Name/Title** **License or Certification Number** **Signature** **Date Signed**

________________________________________________________________________________

**Address** **Phone** **Fax** **Email**