School of PHARMACY HAMPTON UNIVERSITY

Student Medical Leave of Absence Form

STUDENT INFORMATION		
Student Name: Last	First	MI

Student Date of Birth _____ / _____ / _____

OTHER INFORMATION			
Address:	City:	State:	Zip:
Mobile Phone No.:	Other Phone No:		
Email address:			

PHYSICIAN / HEALTH CARE PROFESSIONAL CERTIFICATION INFORMATION			
Physician Name: Last	First	MI	
Address:	City:	State:	Zip:

Please fill in the blanks:

I, __________________________, do hereby certify that I have examined the student _________________________ and have determined that he/she must take a medically necessary leave of absence beginning

on _____ / _____ / _____ and may return to the classroom on _____ / _____ /_____.

Physician's Signature: ___________________________________ Date ____________________

Please note: If for medical reasons, you cannot return on the date indicated by the physician, you must contact the Assistant Dean of Assessment and Student Affairs and submit a new Medical Leave of Absence form.

Please submit this form to the Assistant Dean of Assessment and Student Affairs.

FOR OFFICE USE ONLY

Assistant Dean's Signature: _________________________________ Date ______________________