

# Student Academic Record Petition Medical/Clinical Verification Form



BYU Petitions Office  
B-150 ASB  
(801) 422-6570 / Fax: (801) 422-0615  
E-mail: [petitions@byu.edu](mailto:petitions@byu.edu)  
Website: <http://petitions.byu.edu>

Use Black or Blue Ink Only

## STUDENT INFORMATION

Name (Last, First, Middle) \_\_\_\_\_

Student ID Number \_\_\_\_\_

Class(es) and section number(s) of courses to be withdrawn  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Semester/Term and Year

20\_\_

Winter - January through April

Spring - April through June

Summer - June through August

Fall - August through December

I hereby permit the release of my medical records to the University in order to provide information relevant to my request.

Student Signature \_\_\_\_\_

## PHYSICIAN'S VERIFICATION

Dates of office visits or hospitalization \_\_\_\_\_

Nature of illness or injury \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How much schooling do you believe the student will or did miss because of this illness/injury? \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Submission Instructions:

Please fax (801-422-0615) or mail this signed form (B-150 ASB Provo, UT 84602) to the Petitions Office. If you have any questions or concerns, please contact the Petitions Office at (801) 422-6570.