Governors State University

Office of the Dean of Students
University Park, IL 60484
Room C1310
708.235.7595
deanofstudents@govst.edu
www.govst.edu/studentaffairs
www.govst.edu/DOS

Emergency/Medical Leave Healthcare Provider Form

This form must be completed in its entirety and submitted by the provider. Please type or print clearly in ink.

Section 1: Student Information (Completed by Student)

Student Name: _____ Date of Birth: _____ Student ID#: _____

Permanent Street Address: _____

Phone: _____ GSU student email: _____

Requested Term (Fall, Spring, Summer) & Year: _____

I understand that the information below will be reviewed by the Office of the Dean of Students. I also understand that the Dean of Students may share this information with other GSU officials, as necessary, for review of the Emergency/Medical Leave request.

Signature: _____ Date: _____

Section 2: Medical Information (Completed by Provider)

The above-named student has requested an Emergency/Medical Leave from Governors State University, stating they had a significant condition, such as a serious illness, injury, or hospitalization that prevented them from completing the semester. The student reports that you evaluated or treated them for a qualifying condition. Please complete this form in its entirety, sign, and return to the Office of the Dean of Students using the contact information on the second page.

Provider's Information (a business card may be submitted in place of completing the following):

Name: _____ Title / Degree: _____

Office / Practice: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Assessment & Treatment:

Treatment dates or duration of condition **during the current semester** (Fall, Spring, or Summer):

_____ to _____

Was this patient hospitalized? Yes No If yes, dates of hospitalization: _____

Diagnosis: _____

Governors State UNIVERSITY

Office of the Dean of Students
University Park, IL 60484
Room C1310
708.235.7595
deanofstudents@govst.edu
www.govst.edu/studentaffairs
www.govst.edu/DOS

Medical Status at Time of Assessment / Treatment: Stable or Critical

Type of Condition: Acute or Chronic

Describe the nature and severity of the condition and how the condition and/or medications prescribed to treat the condition, may affect an individual: _____

_____

_____

_____

_____

Recommendation:

By signing below, I affirm that the aforementioned student was/is under my care and that their condition limited or severely impacted their ability to be a student **during the current semester (Fall, Spring, or Summer):**.

Provider's Signature: _____ Date: _____

Provider, please return to:

Office of the Dean of Students
Governors State University
1 University Parkway, Room C1310
University Park, IL 60484

Phone: 708.235.7595
Email: deanofstudents@govst.edu
Fax: 708.631.0167