**Medical Documentation for Financial Aid Appeal**

*\*\*This form is only necessary if you are appealing due to illness/injury. Do not submit medical records. \*\**

**Instructions:** To be completed and signed by a licensed healthcare professional who diagnosed and treated the patient.

**Student Information:**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN/Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the student the patient? YES NO

If no, please state the relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructions for Healthcare Provider**

Your patient (or patient’s spouse or legal guardian) is a student at UA-Pulaski Technical College who is applying for a financial aid appeal to reinstate their financial aid due to circumstances beyond their control. A qualifying circumstance is only for a medical emergency which resulted in the inability of the patent (or patient’s spouse or legal guardian) to attend classes for an extended period of time.

All questions must be answered. If the form is incomplete or missing information, the appeal may be denied for insufficient information. For assistance, contact the Financial Aid Office at 501-812-2289.

**Healthcare Provider Information-to be filled out by healthcare provider only. Do not leave any fields blank.**

Date of initial appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of initial diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of follow-up appointments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the patient admitted into the hospital? YES NO If yes, dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the patient (if student) advised not to work? YES NO If yes, dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the patient (if student) advised not to attend school? YES NO If yes, dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the treatment/procedure medically necessary but non-emergency (i.e. could procedures have been scheduled at a later date and/or during times that would not have interfered with the student’s studies and attendance of classes)? YES NO

Is the patient, guardian, or spouse now able to return to school? YES NO

What was the diagnosis and what impact did it have on his or her ability to carry out their job responsibilities or school work? For pre-existing conditions, please describe the changes that occurred within the term which prevented attendance of classes. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the patient following all recommended courses of treatment(s)? YES NO If no, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthcare Provider’s Signature & Agreement**

*By signing below, you are attesting that the patient was seeking and receiving the proper care, following the proper protocol and medical provider’s orders, and was in no way able to attend and/or participate in classes during the duration noted above. You may be contacted for additional information.*

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT SUBMISSION INSTRUCTIONS** – Please print form and give to your Healthcare provider. Once this form is complete, upload the form with your SAP online form.Healthcare providers may be contacted for verification of information provided on this form.