Date________________________  D.O.B. ______________

RE: __________________________

Dear Health Care Provider:

To process this Physician’s Statement form and eligibility for educational services determined, we need the following information provided or clarified:

- **Statement must indicate Physician’s name** and MUST be signed and dated by a physician (M.D.).

- **A specific date for the student’s expected date of return must be provided.**

- **Complete all student information section.**

- **Complete all Physician information section.**

- **Use checkboxes to indicate type of service and length of service.**

- **Statement must indicate sufficient medical information about why the condition requires the student to be out of school to receive educational services.**

- **Use checkboxes to indicate whether the student’s health will/will not affect the provision of full educational services. If it will, provide explanation.**

- **Please note that the original form and signature is required for our records.**

Sincerely,

Cheryl O’Brien
Administrative Assistant