LOWELL PUBLIC SCHOOLS

DEPARTMENT OF SPECIAL EDUCATION
Henry J. Mroz Administration Office
Edith Nourse Rogers School
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Date_____

RE: _____ D.O.B. _____

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 not that the original form and signature is required for our records.*

Sincerely,

Cheryl O'Brien
Administrative Assistant