



INSTRUCTIONS: The lower part of this form should be completed by the appropriate medical professional and the entire form should be returned in a sealed envelope from the physician's office, with his/her name, address and telephone number inscribed, along with your completed petition, to the appropriate ARC representative at the University of South Florida St. Petersburg, 140 Seventh Avenue South, St. Petersburg, FL 33701.

TO BE COMPLETED BY THE STUDENT:

Student's Name: _____ USF ID: U _____ Relevant time Period: _____

Affected Semester(s) _____ Medical problem pertains to: _____ Student _____ Family Member (Check One)

I am requesting Dr. _____ to release the information requested below to the University of South Florida St. Petersburg Academic Regulations Committee for the purpose of supporting my ARC petition. If you do not wish this form to be stored in your permanent file, please check here: _____.

(Student's Signature)

(Date)

TO BE COMPLETED BY PHYSICIAN:

The student listed above is petitioning the Academic Regulations Committee of the University of South Florida St. Petersburg for special consideration regarding a USF regulation. The student feels a medical problem may have directly or indirectly contributed to the need for such consideration. At the student's request, we would appreciate your cooperation in answering the following questions. Thank you for your assistance in this matter.

Physician's Name: _____ License Number & State: _____

Physician's Address: _____ Telephone _____

Dates you treated this patient or family member: _____

In your opinion, was there a time period that the student was unable to attend class? ___ YES ___ NO

If yes: From _____ Date To: _____ Date

Would length of class be pertinent to the student's ability to attend? (i.e. student could attend a one hour class, but not a three hour lab) YES ___ NO ___ If Yes, please explain:

Would strenuousness of class be a factor in the student's ability to attend? (i.e. could sit for an hour but not be physically active) YES ___ NO ___ If Yes, please explain:

Would this medical condition affect the student's ability to study or engage in class activities for periods of time? YES ___ NO ___ If YES, please explain:

Would medications you may have prescribed have interfered in any way with the student's performance? YES ___ NO ___ If Yes, please explain:

In your opinion would it be medically necessary for the student to withdraw from all classes during the affected term(s)? YES ___ NO ___

In your opinion, would it be medically necessary for the student to reduce his or her course load during the affected term(s)? YES ___ NO ___

Additional Comments: (Please supply comments on letterhead if space is insufficient)

Physician's Signature: _____ Date: _____