Physician's Verification of Medical Condition Form

STEPS 1 and 2 should be completed and returned to Student Health and Counseling Services as soon as possible, and not later than 30 days from the date of withdrawal. The purpose of completing and submitting this form is for SVA to review the tuition liability for the semester stated below for a one time medical tuition waiver. If the form is not completed properly, the student account will not be reviewed. The completed form should be emailed to health@sva.edu or faxed to 212.592.2216.

STEP 1 – To be completed by the student. **Student Medical Authorization**

Student Name: _____ SVA ID#: _____

I hereby authorize the physician to complete the Attending Physician's Statement and to release this and other information to SVA for the documentation of my medical withdrawal.

I understand that by submission of this form I am certifying that my medical condition occurred within and/or required treatment during the semester from which I am seeking a medical withdrawal and prevents me from completing the semester. In submitting this form, I understand that I will not now or in the future receive grades for any classes attended this semester. I understand that if I receive this waiver, it is a one time waiver. Any future medical leaves will not be eligible for review for a waiver. I understand any credit from this waiver will be applied to a future semester at SVA, to be used within the academic year following my withdrawal. If I do not use this credit, it will be voided. SVA recommends purchasing tuition insurance from an outside vendor. SVA does not offer tuition insurance.

Signature: _____ Date: _____

STEP 2 – To be completed by physician. **Attending Physician's Statement**

Your answers to the questions below should clearly establish the medical necessity for a withdrawal from the college.

I hereby certify that _____ has been a patient under my care.
(Student's Name)

Diagnosis/History of Illness: _____

_____

Dates the student was treated for this particular diagnosis/illness: _____

Do you medically certify that the sickness or injury diagnosed prevents the student from completing the rest of the current semester? _____ (Yes/No). Hospitalization date(s), if applicable:

Reason that student needs to withdraw: _____

_____

When do you anticipate the student will be able to resume classes at SVA? _____

Signature of Physician: _____, MD. Date: _____

Please print name: _____ License #: _____

Address: _____ Phone #: _____