ANAHEIM UNIVERSITY
PETITION FOR SPECIAL MEDICAL LEAVE OF ABSENCE

Student #_____

I, _____, , would like to petition for a medical leave of absence from the _____degree program at Anaheim University in which I am currently enrolled. I request this leave of absence for the following reason (State the specific reason for your petition and the nature of your medical problem):_____
_____
_____
_____
_____
_____

To be completed by student prior to submitting to Physician

Have you ever applied for any form of leave of absence from this university in the past?
_____No _____Yes
If yes, how many times, for how long and when?_____

For what period do you require a leave of absence?
30 days _____ 60 days _____90 days _____

From what date to what date do you wish to be excused?_____

Note: The maximum period of a leave of absence is ninety (90) days per leave. Students may apply for a maximum of four (4) leaves of absence for medical reasons throughout their degree program. Each leave of absence must be ninety (90) days or less and requires a separate petition which must be approved by the University's administration. Only students in good academic and financial standing will be considered for approval of leave.

I hereby authorize _____of _____
(Doctor's name) (Hospital, clinic or medical facility)

to release/disclose within this form information related to the nature of my health conditions that are temporarily preventing me from pursuing my university studies. I hereby promise that all of the information provided in this form is true and correct. I understand that any falsification or misinformation provided in this form may be grounds for immediate dismissal and forfeiture of all financial payments and academic credits.

_____ _____
Signature Date

To be completed by attending Physician

1)

☐ I speak and read English and understand all of the information in this form.

OR

☐ I am not fluent in English and require a translation in the _____ Language.

Note: all translations must be notarized by a notary public and attached to the original English form. Translations in foreign languages that are not notarized will not be accepted.

2) I hereby certify that I have provided health care services to:

_____, since _____.
(Name) (Date)

I am completing this form to assist the university in assessing what special consideration, if any, should be given to the individual named above in respect to a medical leave of absence. I am aware that the student is enrolled in a distance learning/online academic program of study and does not attend regular on-campus classes.

3) What is the nature of the patient's illness or health problem? _____

4) What treatment is the patient currently receiving that may prevent the patient from concentrating on his/her studies? _____

5) In your professional opinion, how does the patient's health situation adversely affect the patient's ability to pursue his or her studies. Please check the appropriate boxes below:

Patient's health condition prevents him or her from:

_____Reading
_____Typing
_____Attending on-campus classes
_____Traveling via airplane
_____Concentrating for extended periods of time
_____Other. (Please explain:_____

6) In your opinion, what period of medical leave should be granted?

_____Less than 1 month
_____1 month
_____2 months
_____3 months
_____more than 3 months. If so, how long?_____

_____
Physician's Name (Please print)

_____
Physician's Signature authorizing the above is True and correct.

_____
Date

_____
Physician's Specialization

_____
Telephone Number

Address (Stamp or business card acceptable)

_____
E-mail address (if available)

Please retain copy for patient's file/chart. **Note**: any fees relating to the obtaining of this certificate are to be paid by the patient.

For University Administrative Use Only

Approved by:

Rejected by:
Reason: