REGISTRATION APPEAL

MEDICAL VERIFICATION OR MEDICAL CARETAKER VERIFICATION FORM

A Registration Appeal is a petition filed by the student to be withdrawn past the published deadline due to a personal extenuating circumstance that occurred during the semester. This form is for students or their immediate family members who experienced a serious medical circumstance that prevented the student from attending or participating in class(es). Medical provider verification is required to confirm the circumstance.

STUDENT INFORMATION AND RELEASE

(To be completed by the student.)

I authorize the release of my medical records/information to Salt Lake Community College to provide details relevant to my appeal, such as grades and class schedule, to my medical provider (named below) as needed to accurately evaluate my request.

Student's Name: _____
Student's ID Number: _____

Student's Signature: _____ Date: _____

MEDICAL PROVIDER VERIFICATION

(To be completed by the medical provider.)

Medical circumstance duration: From _____ to _____ (Leave "to" blank if ongoing).
MM/DD/YYYY *MM/DD/YYYY*

Semester affected: _____
Semester/Year (e.g. Fall 2024)

Brief description of medical circumstance:

_____
_____

Did the medical circumstance affecting the student or their immediate family member begin before the semester started? Yes ___ No ___

If you answered "yes", did the student or their immediate family member experience an unexpected change (e.g. worsening of condition, surgery or hospitalization, new medication or treatment plan) in their medical circumstance? Yes ___ No ___

In your medical opinion, do you believe this medical circumstance prevented the student from being successful during the appealing semester? Yes ___ No ___

Comments:

_____
_____

MEDICAL PROVIDER VERIFICATION

(To be completed by the medical provider.)

The Salt Lake Community College Registrar's Office may contact you to confirm that the information provided on this form is not fraudulent or altered, or to obtain clarification regarding the appeal.

Printed Name (and post-nominals): _____ License #: _____
Name of Practice/Clinic: _____
Email: _____ Phone: _____

Signature: _____ Date: _____

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