Samford University
Global Engagement Office

Samford University
Global Engagement Office
Brooks Hall 221
geo@samford.edu

Recommendation for a Reduced Course Load Due to an Illness or Medical Condition

To be completed by a Licensed Medical Doctor, Doctor of Osteopathy or Licensed Clinical Psychologist

A student may be authorized to enroll in less than full-time coursework, or if necessary, in no classes at all due to a temporary illness or a medical condition. An aggregate of 12 months is the maximum time a student is allowed this exception to full-time enrollment. This form is valid for one semester only.

In accordance with 8CFR 214.2(f)(6)(iii)(B), in order to authorize a reduced course load, the student must provide to the Global Engagement Office medical documentation from a licensed medical doctor, doctor of osteopathy or licensed clinical psychologist.

This form with an attached business card can be mailed or emailed to:

The Global Engagement Office
Samford University 800 Lakeshore Drive
Birmingham, Al. 35229
205-726-2741
geo@samford.edu

Your assistance in completing this form is greatly appreciated.

Student's name:

Semester for Recommended Reduced Course Load:

Due to illness or medical condition, I recommend *(check one)*:

- ☐ **a reduced course load this semester.**
- ☐ **total withdrawal (no enrollment) this semester.**

Estimated Length of Problem:

Health Care Provider's Name:

Signature:

Date of Signature:

Address and Phone Number:

Additional Comments:

Samford University
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800 Lakeshore Drive
Birmingham, AL 35229

MEDICAL RECORDS AND RELEASE FORM

1. I authorize the following protected health information to be released from the health record of:

Patient's First Name: **Last Name:**

Phone Number: **SU ID:** **Date of Birth:**

2. Information to be released from your record:

Entire record ☐ **Office visit notes** ☐ **Immunization record** ☐

Lab results ☐ **Mental Health information** ☐ **Alcohol/Drug Treatment** ☐

3. A representative of Global Engagement Office at Samford University may discuss my treatment with the following persons:

Name: **Relationship:**

Name: **Relationship:**

4. Signature of Patient

- I understand that signing this form is voluntary.
- Unless otherwise revoked, this authorization will expire on (date or event). If I fail to specify an expiration date or event, this authorization is valid for one (1) year from the date of my signature.
- I may revoke it by sending a written notice to the Global Engagement Office stating my intent to revoke this authorization.
- I understand that the records released may include information related to mental health.
- I understand that the records released may include information related to HIV or AIDS.
- I understand that the records released may include information related to the treatment for and/or /history of drug or alcohol abuse.
- I understand that information disclosed under this authorization might be re-disclosed by the recipient and may no longer be protected by privacy laws.
- I understand that a photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original.

I have read and fully understand the above statements and consent to the disclosure of my health record to the extent state above.

Student Signature: **Date:**