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Division of Student Affairs
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PRIMARY CAREGIVER CERTIFICATION FORM

Section I: For Completion by the STUDENT
Please complete Section I before giving this form to your family member's medical provider. Failure to provide a complete and sufficient medical certification may result in denial of your Exceptional Circumstance Withdrawal request.

Name of student: _____ Z#_____

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

Student Signature: _____ Date: _____

Section II: For completion by the HEALTH CARE PROVIDER
The student listed above has requested an Exceptional Circumstances Withdrawal (ECW) to care for your patient. Answer fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine ECW approval. Limit your responses to the condition for which the patient needs care. Please include your license number and signature on the last page.

Provider's Name and business address: _____

_____

Type of practice / Medical specialty: _____

Telephone: ( ) _____ Fax: ( ) _____

Part A: Medical Facts

1. Approximate date condition commenced: _____
2. Probable duration of condition: _____
3. Was the patient hospitalized?: _____ Dates of admission: _____

4. Date(s) you treated the patient for condition: _____

_____

5. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

Part B: Amount of Care Needed

When answering these questions, keep in mind that your patient's need for care by the student seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

6. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? Yes_____ No_____

   If yes, estimate the beginning and ending dates for the period of incapacity:

   _____

   During this time, will the patient need care? Yes_____ No_____

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

7. Will the patient require follow-up treatments, including any time for recovery? Yes_____ No_____

   Estimate treatment schedule, if any, including:

   Dates of Scheduled Appointments: _____

   Time Required for Each Appointment: _____

   Recovery Period Required: _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

8. Will the patient require care on an intermittent basis, if any:

   _____Hour(s) per day _____days per week From: _____through_____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Name of Treating Professional (Please Print) **Signature of Treating Professional** **Date**

Please stamp with office stamp or write license number here (required):_____

Please return to the following address listed below:

- **Completed questionnaire**

  Dean of Student Affairs
  Florida Atlantic University
  Bldg. 8, Room 226
  777 Glades Road
  Boca Raton, FL 33431
  561-297-3542