## SOUTH INDIA TERM ABROAD - REFUND APPEAL MEDICAL SUPPLEMENT

### STUDENT NAME AND SIGNATURE

Last _____ First _____ Home Institution _____

Signature of student authorizing release of medical information.

Signature _____ Date _____

### INSTRUCTIONS FOR PHYSICIAN

This form is to be completed by a physician/medical professional, and will be used to help the student with documentation for an exception to a SITA refund policy. If additional space is needed, attach a separate letter on letterhead providing further information.

Patient was seen for medical condition on (list all dates): _____

Length of treatment: _____

Was the student physically/emotionally incapable of attending classes during the term of illness? __ Yes __ No

List specific symptoms and how they prevented the student from attending class(es): _____

_____

Did you recommend ongoing treatment/therapy? __ Yes __ No

When do you believe the student can/could resume daily activities, including attending class(es)? _____

_____

Do you believe the student is currently fit to study abroad in India? _____

Other comments pertinent to the student's circumstances: _____

_____

### SERVICE PROVIDER SIGNATURE

By signing below, you are certifying that the information you provided is true to the best of your knowledge.

Name _____ Title _____ Phone _____

Signature _____ Date _____