UCF | Dining Services

UNIVERSITY OF CENTRAL FLORIDA

MEDICAL EXEMPTION REQUEST 2018-2019

FORM A

To Be Completed by the Student

If you are requesting special consideration for release from the Dining Membership for medical reasons, you should complete this form in accordance with the following guidelines:

1. Complete Forms A and B and return the forms in their entirety to the Dining Membership Committee. **Form A must be sent by the student by mail only. Form B must be sent by the physician(s) by mail only.** All mail must be sent to the attention of the Dining Membership Committee, 4115 Pyxis Lane, Orlando, FL 32816.
2. You are responsible for having your physician(s) complete all of the questions on Form B and return it to the Dining Membership Committee in order for the request to be considered. All medical information and files will be kept confidential in accordance with FERPA regulations.
3. Your physician(s) documentation must provide enough detail to allow the Registered Dietitian, Auxiliary Services and Dining Services to make an independent judgment of the need for your request. The physician's area of specialty must coincide with your medical request.
4. It is important that all Dining Membership deadlines be met in order for a timely decision to be made. Reference the UCF Dining Membership Agreement 2018-2019 for cancellation request deadlines.
5. Exemption from the Dining Membership cannot be guaranteed.
6. Please note: You will be charged for your Dining Membership until the date the exemption is granted.

Release of Medical Information

Please read below. Print or type legibly. Fill your name in the blank below, sign the document and have someone witness your signature. This form must be complete to be considered.

I, _____, hereby authorize and instruct the physician(s) named below to release all information from my medical records which pertain to my request for a medical exemption, including drug, alcohol, and mental health treatment, to the Dining Membership Committee at the University of Central Florida.

For each physician listed below, a FORM B must be submitted.

Physician(s): _____ Telephone Number: _____

_____ _____

_____ _____

_____ _____

Witness Signature

_____ _____

Date

_____ _____

Student's Signature

_____ _____

Date

_____

UCF ID

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FORM B

Section I: Completed by the Student (Please print or type. Information must be legible.)

Student Name: _____ Date of Birth: _____ UCF ID: _____

Semester for which medical exemption is being sought: _____

Reason for medical exemption: _____

_____

Dates of hospitalization, if any: _____

Steps you have taken (i.e. counseling with UCF Dining Services Residential Managers, other treatment) to address/resolve your concerns for exemption: _____

I hereby certify that my condition is of such severity that I am unable to carry out the UCF Dining Membership for the remainder of the term. ☐ YES ☐ NO

Student's Signature: _____ Date: _____

Section II: Completed by Physician/Treatment Provider (Please print or type. Information must be legible. Your clear and precise response is important. Processing of student's request will be delayed is this section is not completed.)

Provider Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

A Your Treatment of the Student

____ Medical ____ Psychological ____ Psychiatric ____ Alcohol/Drug ____ N/A

Your specialty: _____

Dates seen: (From) _____ (To) _____

Total # of sessions/appointments: _____

Patient's condition/diagnosis: _____

Specific dietary requirements needed to treat the condition/diagnosis: _____

_____

Medications and/or treatments prescribed that may interfere with the continuation of the dining membership: _____

_____

Current status (check one): _____ Stable _____ Requires periodic follow-up

_____ Requires ongoing care _____ Unstable

Will you continue to provide services to the student? _____ Yes _____ No

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FORM B

B. Criteria for Medical Exemption

It is expected that all providers who submit documentation on behalf of a student pursuing a medical exemption will have been the student's treatment provider during the period of disabling illness. The documentation provided should be sufficient to substantiate the severity of the student's condition during the semester in which medical exemption is being sought**.** The impairment must reflect a severity level which substantially interfered with activities of daily dining.

C. Your Assessment of the Student's Condition

Please provide a written statement describing the severity of the student's condition and how it affected his/her dining functioning and ability to maintain a dining membership.

_____
_____
_____
_____
_____
_____
_____
_____

D. Certification

I hereby certify that the above-named student's condition reflected a severity level which substantially interfered with her/his activities of daily living such that she/he was unable to carry out the remainder of the dining membership.

_____ YES _____ NO _____ Unable to Certify Due to Insufficient Information*

* If you are unable to certify the required severity of the condition, you may still provide any relevant information.

Signature of Provider: _____ Date: _____

(Interns who are completing this form should have their licensed supervisor co-sign.)

Please forward this original form to the Dining Membership Committee at the address below.

Faxes will not be accepted in lieu of the original form.

This form will not be accepted if hand-carried or mailed in by the student.

Thank you.

Dining Membership Committee

University of Central Florida

4115 Pyxis Lane

Orlando, Florida 32816