



Health Care Provider Verification Form for Tuition Forfeiture Petition

STUDENT FISCAL SERVICES
1400 NE Campus Parkway | 129 Schmitz Hall - Box 355870
Seattle, WA 98195-5870

Phone (206) 543-4694
FAX (206) 685-2942
Email: sfsforms@uw.edu

INSTRUCTIONS FOR COMPLETING THIS FORM:

A licensed healthcare provider may complete this form as a supporting document to accompany a student's FQD petition. Examples of licensed healthcare providers include mental health counselors (LMHC), social workers (LICSW), marriage and family therapists (LMFT), psychologists (Ph.D. or Psy.D.), nurses and nurse practitioners (RN or NP), physicians (MD or ND), and any other licensed health/mental health provider.

Once the form has been completed, it can either be returned to the student to submit to the school, or sent to UW directly by the provider.

TO BE COMPLETED BY THE STUDENT:

Student Name (Last)		(First)	(Middle Initial)
UW Student ID Number	Email	Petition Quarter/Year	
By signing below, I give my consent for my healthcare provider to provide information to the University of Washington by completing this form in evaluation of my medical records.			
_____ Signature of Student		_____ Date	
_____ Signature of Parent/Guardian if student is under the age of 18		_____ Date	

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL:

Healthcare Provider Name	Credentials and Licensing Information
Healthcare Practice/Facility Name	
Address/Website	
Phone	Email

I support the above student's need to withdraw or reduce credits for a tuition forfeiture petition for the quarter(s) indicated above due to extenuating circumstances beyond the student's control (check one): Yes No

Healthcare Provider Signature: _____ Date _____