

Dear Student: Please complete this section.

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Group **AMA-sponsored Med Plus Advantage**

Dear Provider: We are currently working with your patient to assist him/her/them by understanding their limitations and restrictions in order to provide the right accommodations that will allow him/her/them to successfully remain at school or return to their studies. ***Please include results of diagnostic testing and pertinent chart notes.***

1. Diagnosis (include the ICD code) \_\_\_\_\_  
 \_\_\_\_\_

Date of most recent visit \_\_\_\_\_ Frequency of visits \_\_\_\_\_

Expected duration of impairment from this condition \_\_\_\_\_

2. Describe your patient's current symptoms: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. What are your patient's limitations and restrictions? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Planned course of treatment (include expected duration): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.**

Physician's Signature		Date	
Physician's Name (please print)		Specialty	
Address	City	State	ZIP
Phone No.	Fax No.		

**Please submit via DocuSign or fax completed form to: 971.321.5727/855.207.6115**