Excelsior Scholarship Eligibility Determination Form
Section V – Medical Information

V. Medical Information

If you have indicated on the Excelsior Scholarship Eligibility Determination Form Section I – IV, that you have/had a medical diagnosis that required that you to leave school or attend less than full time, your licensed physician/health care provider must complete this section.

Student Information

First Name	Last Name	M.I.
College	Student ID	Date
Phone	Email	Academic Year

To be filled out by your licensed physician/health care provider.

The above patient is an applicant for a NYS scholarship administered by the Higher Education Services Corporation (HESC). The Excelsior Scholarship Eligibility Determination Form will be reviewed and processed by The City University of New York – CUNY.

For CUNY to make an eligibility determination, please provide the following information. Use additional sheets, on physician/ health care provider's letterhead, if necessary. Please complete section V in its entirety. Incomplete medical information may result in the denial of the student's application.

1. Was it your medical recommendation that the student stop and/or reduce their college coursework based on his/her medical condition?

☐ Yes ☐ No

2. Please indicate the period when the student's medical condition impacted his/her college attendance:

☐ Student needed to stop his/her college studies

This occurred from (start to end) _____ to _____

☐ Student needed to reduce his/her college course load.

This occurred from (start to end) _____ to _____

3. If applicable, did the student's medical condition necessitate a change in his/her program of study?

☐ Yes ☐ No

4. Did the student change the college he/she attends due to the medical condition?

☐ Yes ☐ No

5. Briefly explain how/why this student's medical condition impacts his/her college attendance and if this student has any restriction upon returning to his/her college studies.

6. Additional Documentation attached ☐

Physician/Health Care Provider Affirmation

By signing below, I affirm, under the penalty of perjury that the information I provided is true and complete based on my professional medical judgment and the medical records maintained in the ordinary course of business.

Physician/Health Care Provider Signature

Date

Print Name

Professional License Number/State

Phone Number

Physician's Stamp