REQUEST FOR SHORT-TERM MEDICAL OR PARENTAL RELEASE

Note: A parental leave or short-term medical leave request must be submitted with written certification from a health care provider and written permission by the graduate student that an official of the University may contact the certifying health care provider, if needed. A short term parental leave is a leave of six weeks. A short term medical leave is a leave of up to six weeks. For more information, please see ga.rice.edu "Leaves, Interruptions of Study and Withdrawal." If you need more than six weeks, contact GPS at 713-348-4002.

Name: ___________________________________ Student ID: ____________________________

Date: ___________________________ Department: ____________________________

Degree sought (e.g. M.A., M.S., and Ph.D.): ______ Have you achieved candidacy? □Yes □No

If yes, date candidacy approved _______________ If no, date candidacy expected _______________

Are you receiving a stipend? □ Yes □ No  Are you receiving a tuition waiver? □ Yes □ No

LIST the dates of the requested leave: __________________________________________________________

State specifically why you are requesting this leave.

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

☐ Attached is a written certification from the relevant health care provider.

☐ My health care provider has been given written permission to speak to the Dean of Graduate and Postdoctoral Studies, the Director of the Rice Counseling Center, and the Director of Student Health Services regarding my condition.

Student Signature  Date  Department Chair signature  Date

Advisor Signature  Date

RETURN TO GRADUATE COORDINATOR FOR SUBMISSION
Authorization to Release Medical Information

I, _________________________________, authorize my health care professional, _________________________________, to release information about my medical condition to Rice University’s Office of Graduate & Postdoctoral Studies, for the purpose of assessing enrollment and academic considerations.

Signed, __________________________ Date: __________________________

SUBMIT TO YOUR HEALTH CARE PROVIDER

Graduate & Postdoctoral Studies Fax #: 713-348-3222
Rice University now offers an Online Child Care Search tool. Click on this link, https://www.collabforchildren.org/families/Rice, and login with "Rice" using the password "Riceowls01". Do not include the quotation marks; the password is not case sensitive.