HEALTH CARE PROVIDERS must be licensed to practice and cannot be an immediate family member. **AMA Code of Ethics E-8.19**

Check either 1 or 2 in the appropriate box below. Only disclose information that is necessary and relevant to UCEAP’s health clearance process.

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**Licensed SPECIALIST or PSYCHOTHERAPIST**

Section & signature only required if student is being treated by one.

1. [ ] **CLEARED** (Check all that apply below)
   - [ ] 1.a No medical or psychiatric contraindications to UCEAP participation.
   - [ ] 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC disability services office documenting the disability and indicating who will pay for services is required.
   - [ ] 1.c Student strongly advised to continue treatment abroad (e.g., counseling, medical monitoring, etc.). Indicate that student has treatment plan in place and is stable.
   - [ ] 1.d Student advised to find out if medication (or appropriate substitute) is locally available. Student advised to carry a sufficient supply to last through entire program (if allowed by customs). If on medication, please list.
   - [ ] 1.e List significant allergies (e.g., medication, food, etc.):

Complete notes on back of form if necessary.

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2. [ ] **NOT CLEARED**: There are medical or psychiatric contraindications to UCEAP participation.

Licensed Specialist: **PRINT LEGIBLY name and title**

Signature: ________________________________

Date Phone #

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**Licensed GENERAL PRACTITIONER (MD, DO, NP, RN, or PA)**

Section & signature required for all students.

1. [ ] **CLEARED** (Check all that apply below)
   - [ ] 1.a No medical or psychiatric contraindications to UCEAP participation.
   - [ ] 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC disability services office documenting the disability and indicating who will pay for services is required.
   - [ ] 1.c Student strongly advised to continue treatment abroad (e.g., counseling, medical monitoring, etc.). Indicate that student has treatment plan in place and is stable.
   - [ ] 1.d Student advised to find out if medication (or appropriate substitute) is locally available. Student advised to carry a sufficient supply to last through entire program (if allowed by customs). If on medication, please list.
   - [ ] 1.e List significant allergies (e.g., medication, food, etc.):

Complete notes on back of form if necessary.

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2. [ ] **NOT CLEARED**: There are medical or psychiatric contraindications to UCEAP participation.

Licensed General Practitioner: **PRINT LEGIBLY name and title**

Signature: ________________________________

Date Phone #

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**Upon completion**, keep one copy on file and give the original to the student to mail by the stipulated deadline to:

UCEAP, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117

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