



## STUDENT'S DOCTOR

Name \_\_\_\_\_

Phone No. \_\_\_\_\_ Email address \_\_\_\_\_

Address \_\_\_\_\_  
number street city postal code

### **PART B:**

A medical certification of need is required to access HHI. This is a written letter from the appropriate medical personnel. The contents of this letter is found on page two of the attached HHI policy.

Medical Statement Enclosed:  yes  no

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Signature of Director of Curriculum and Instruction

Date

### **PART C:**

- Date of commencement of home/hospital instruction \_\_\_\_\_
- Estimated date of return to school: \_\_\_\_\_
- Home/hospital instruction teacher: \_\_\_\_\_
- Classroom teacher: \_\_\_\_\_
- Proposed program: \_\_\_\_\_
- Location of home/hospital intruction: \_\_\_\_\_

## **AUTHORIZATION**

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Signature of Chief Academic Officer

Date

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Signature of Chief Executive Officer

Date