



## STATE-APPROVED SPECIAL CONSIDERATIONS

### FORM 3: *TREATING PHYSICIAN/MENTAL HEALTH WORKER FORM* (page 1 of 2)

“Request for Exemption due to Medical Reasons or Student Personal Crisis”

**[Notes to District: 1) Give Form 3 to the treating physician/mental health worker along with Form 3A (Attachment). 2) Do NOT send completed Form 3 to RIDE. Please retain with student records]**

**Student Full Name:**  
(please print)

As the treating physician, you are in a position to advise the parents and educational team regarding a request for medical emergency exemption from statewide assessment for the student listed below. It is the purpose of this document to inform the context of the advice you provide in response to this request. It is the responsibility of the public district to review in a timely manner all requests for Medical Exemption that would permit any student to be exempted from statewide assessment for reasons of medical emergency. The criteria below include the minimum conditions that must be addressed in order for the RI Department of Education to grant a student a special consideration exemption from statewide assessment.

TREATING PHYSICIAN’S/MENTAL HEALTH WORKER’S ASSURANCES		<i>Please mark appropriate response for each assurance and initial</i>		
<i>Note to Physician: <u>Before</u> responding to the questions below and signing this document, please read the attachment on the <u>next page</u> to inform your answers.</i>		<b>Yes</b>	<b>No</b>	<b>Initials</b>
<b>1</b>	There is a <b>medical emergency</b> or <b>serious illness</b> or <b>personal crisis</b> (please circle the appropriate response) that prevents this student from receiving instruction during the remaining test window.			
<b>2</b>	This student <b>cannot participate in INSTRUCTION—regardless of setting</b> (e.g. school, home, hospital)—even with accommodations, during the remaining test window.			
<b>3</b>	This student <b>cannot participate in ASSESSMENT</b> , even with accommodations, during the remaining test window.			

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**Signature of Treating Physician/Mental Health Worker**

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**Date**