David Geffen
School of Medicine

Clearance to Return to David Geffen School of Medicine at UCLA
Curriculum / Clerkships

Date: _____

To UCLA Student Affairs Office:

Please be advised that _____ has been under my care
Student Name (please print clearly)

from _____ to _____. He/she was not able to be in the curriculum/clerkships
MM/DD/YY **MM/DD/YY**

from _____ to _____. He/she is cleared to return for normal school activity/clinical
MM/DD/YY **MM/DD/YY**

cleared to return for normal school activity/clinical rotations beginning _____.
MM/DD/YY

Restrictions following return?

No: ☐ Has no problems that will interfere with meeting expectations and is not a health risk to patients, other students or staff

Yes (please specify):

_____

_____

_____

If restrictions, student will be able to return for normal school activity/clinical rotations without restrictions on

_____.
MM/DD/YY

Sincerely,

_____ _____
Health Care Provider Signature **Name (please print clearly)**

_____
Address

_____ _____
Contact Number **E-mail Address**

Office use only

Approved to return as of _____

Restrictions ? _____

_____

_____ Date: _____
Lee Miller, M.D., Associate Dean