DENISON

Request for Medical Withdrawal
Health Care Provider Report

This Medical Withdrawal Provider Report form must be completed in full. Please type or print clearly in ink.

Student Name: _____ Denison ID#: _____

Date of Birth:_____ Cell Phone: _____

Personal (non-Denison) Email:_____

Academic semester student is requesting for medical withdrawal: _____

Dates of medical withdrawal: _____

Anticipated Semester of Return: _____

I, (student name) _____, hereby authorize the treatment provider or team named below to exchange information pertaining to my evaluation and/or treatment for the purpose of assessing my academic functioning level, safety, and readiness to return from medical withdrawal.

_____

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for one year thereafter

ending on: _____

I have been informed that I may revoke this authority by written communication to the provider named at any time. I certify that this form has been fully explained to me and that I understand its content.

I understand and consent to the following: the information below will be reviewed by Denison's Office of Student Life and/or Denison's medical or counseling staff. I also understand that this information may be shared with other Denison University officials, as needed for the purpose of reviewing the Medical Withdrawal request.

_____ _____

Signature of Student Date of Authorization

_____ _____

Signature of Witness Date

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Dear Provider:
The above-named person is requesting a medical withdrawal from Denison University based on a condition that is preventing them from meeting the normal expectations of a student. The student reports that you have evaluated or treated them for this condition during this period. Please complete the following form in its entirety with sufficient information that enables Denison to understand and substantiate the basis for a medical withdrawal. Please then sign and return this form.

Email: ducares@denison.edu/FAX: 740-562-6318/ Student Life, 100 West College Street, Granville, OH 43023

- We are interested in obtaining information about your recommendations for this student while they are on a medical withdrawal.
- Given the rigor and challenges of the academic and social environment to which the student will return, we would like to know whether under certain conditions you feel the student will be healthy enough to continue pursuing education.
- It is important that we have as much information from you as is possible so we can support the student's success upon return.
- A Readiness to Return form must be submitted upon students request to register for classes. The student is asked to present this form at the outset of treatment after beginning the medical withdrawal. Providers may use their own Release of Information form in addition to the form provided by the Denison Medical Withdrawal Team.
- If necessary, attach additional documentation to expand on your responses and comments regarding the student and their ability to function safely, stably, and successfully as a full-time university student.

Provider's Name: _____

Provider's Title/Degree:_____

Provider's area of medical/mental health specialization: _____

Office Address: (address, city, state, zip)_____

Phone and Fax:_____ Email Address:_____

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Part A: Medical information

Student Name: _____ Birthdate:_____

1. Type of condition – check all that apply

___ The condition is medical in nature
___ The condition is psychological in nature
___ Drug and/or alcohol concerns

2. *Length of treatment/assessment for this condition(with dates):* _____ ([date] to [date])

3. *Total number of sessions / appointments*

4. *Medical facts underlying the medical withdrawal request:* Please explain the medical facts, including diagnoses, date the condition began, and the expected duration, of the circumstances underlying the medical withdrawal request.

5. *Treatment plan:* (Please include information on medications, in-patient/outpatient therapies, surgeries, etc. Please indicate where treatment is current/ongoing and recommended treatments during the student's time away. If further evaluation/consultation is expected, please explain.)

6. Will you continue to provide services for this student? Will additional care be sought, and if so, with whom?

7. Other recommendations for follow-up/care that you have communicated to the student.

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Part B: Assessment

1. The student cites the medical condition as the basis for being unable to meet the normal expectations of a student at this time. (This could include where the medical condition prevents engagement in or completion of academic course work, self-care, or where the student's safety is in jeopardy or they pose a threat to others). Is it your medical opinion that the condition is causing the student to be unable to meet the expectations of being a student at this time? Please explain.

Please include any additional elaboration and/or documentation that would enable Denison to understand the condition, your assessment, and substantiation of the basis for a medical withdrawal.

Signature of Provider: _____Date:_____

Clinician Information (If part of a treatment program, please include facility name, address and phone)

_____ _____ _____
Clinician Name License State of Practice

_____
Address

_____
Phone Number

_____
Email

_____ _____
Signature Date

Please return this form to:

Denison University Student Life
Attention: Medical Withdrawal Team
Email: ducares@denison.edu
Fax: 740-562-6318