Request to Return from Medical Withdrawal

First and Last Name: _____ Date of Birth: _____

Term for which you are seeking reinstatement and return:(Fall/Spring+Year) _____

Denison ID#: _____ Original Class Year:_____ Cell Phone #:_____

Personal Email Address: (required)_____ Current Address:_____

Major (if applicable):_____ Faculty Advisor: _____

Are you an international student and would you be studying at Denison on a visa? _____

Name of healthcare professional you have seen who recommend or support your return from a Medical Withdrawal:

Name of healthcare professional: _____

Date of recommendation: _____

Healthcare professional documentation, in the Readiness to Return Form, must include:

1. Your medical condition with diagnosis,
2. Statement specifying recommendation or support for re-enrollment, and
3. Description of recommended follow-up care upon return to school.

Please initial on each line to indicate that you have read and understand:

_____ I have read the Withdraw-Medical Agreement listed on the Denison website. I understand my return from a MLOA will not be reviewed until all documentation has been received by the Medical Withdrawal Team.

_____ I understand all supporting documentation for consideration for re-enrollment must be received by Denison on **July 1** for a fall start and **November 1** for a spring start.

_____ I understand that re-enrollment from a Medical Withdrawal requires:

- a completed Request to Return from Medical Withdrawal form
- appointment confirmation with a provider outside of Denison, after the start of the term
- a description of care given during the withdrawal period by a healthcare provider
- a healthcare professional's completed Readiness to Return form

_____ I understand requesting re-enrollment does not guarantee or reflect approval of re-enrollment. Confirmation of re-enrollment will be sent to my Denison email and the alternate email listed below.

_____ I am responsible for understanding and addressing all academic, financial, and health insurance-related ramifications of taking a medical withdrawal, and that I am required to contact my Academic Advisor to discuss my academic plan upon re-enrollment from medical withdrawal.

Student's Signature: _____ Date: _____

Please return this form to: Denison University Student Life, Attention: Medical Withdrawal Team
Email: ducares@denison.edu

- If you receive financial aid, please contact the Financial Aid Office to understand the implications of taking a Medical Leave of Absence. 740-587-6276 | Doane Administration 1st Floor
- If you are an international student, please contact the Center for Global Programs to review the implications of taking a Medical Leave of Absence. 740-587-6532 | Burton D. Morgan Center 4th Floor

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Reflective Statements

Please provide thoughtful, reflective, and personal responses to the following questions. There is no length requirement for your response. It is important that you share all information you believe is necessary for us to gain a complete understanding of your wellness and readiness to return to Denison.

1. Describe the activities, including treatment and recovery, that you engaged in during the time away.

2. Describe your perspective on your recovery and why you feel you're ready to return to the demands of academic and campus life at Denison. Please include here, if applicable, any recommended physical or mental-health maintenance strategies you have been working on during the time away and your plan for implementing those on return (this information helps Denison assess a student's readiness to return and also helps us understand what campus resources we can bring to students' attention to help them flourish).

3. Describe all ongoing treatment recommended by your provider (if any). Please also explain your plans to ensure the availability of any recommended ongoing care upon your return and its compatibility with the expectations of academic and residential campus life.

Release of Information

Authorization to Release/Obtain/Exchange Confidential Information

Patient Name: _____ _____ _____
Last First Middle Initial

Date of Birth: _____ Denison ID Number: _____

Phone Number: _____

Record to be RELEASED FROM: (check box)

☐ Hoaglin Wellness Center (Medical & Counseling Services)

Information to be RELEASED BY: (check all that apply)

☐Email ☐ Phone ☐Fax

The Specific Purpose of this Disclosure (check only one box)

☐ Request for Medical Withdrawal
☐ Request to Return from Medical Withdrawal

Protected Information to be RELEASED TO:

☐ Medical Withdrawal Team *(Based on your needs this could include Hoaglin Wellness Center, Class Dean Office, Residential Communities and Housing, ARC, Office of Community Values and Student Conduct, and Office of First-Year Experience)*
☐ Other: _____

Protected Health Information to be Disclosed:

☐Returning Student: Upon review of pertinent health and treatment information provided, the Hoaglin Center clinician will provide a professional opinion regarding the impact of condition on the student's ability to be academically successful, based on their course of treatment, and continued treatment plan while at Denison.
☐ Other
_____

_____ _____
Student Signature Date

_____ _____
Parent/Legal Guardian Signature (for Students 17 years of age or younger) Date

This release expires upon graduation from Denison University
This authorization may be revoked by the patient, in writing, at any time, except for information which has already been released in accordance with this authorization prior to the patient's revocation.

PROHIBITION ON REDISCLOSURE

The information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.