Request for Return from Medical Withdrawal
Readiness to Return
Health Care Provider Report

Section 1: To be completed by the student:

Student Name: _____ Date of Birth:_____

Denison ID#:_____ Cell Phone #:_____

Personal (non-Denison email):_____

Semester (fall/spring) and year for which reinstatement and return are requested: _____

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 health center 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

DENISON

Please have your provider fill out this section. If you are seeing more than one health care provider, please copy this form, have each provider complete it, and then email the completed forms as PDF email attachments to the Medical Withdrawal Team.

Dear Provider:
The above-named person was previously granted a medical withdrawal by Denison University and is requesting to return to campus and full academic participation and residential campus life. The student reports that you evaluated and/or treated them while they have been away on medical withdrawal. Please complete in its entirety the following information regarding the student's current condition and any ongoing and recommended treatment plan. Please then sign and submit this form and any associated materials pursuant to the address or fax number below.

- 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.

Student's Name: _____ Date of Birth: _____

Provider's Name:_____ Provider's Title/Degree:_____

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

Office Address: (Address, City, State, Zip: _____

Office Phone and Fax: _____ Email:_____

DENISON

Part A: Medical information and follow-up plans:

1. Type of condition that was the basis for the medical withdrawal – 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 the condition that was the basis for the medical withdrawal (with dates):
_____ ([date] to [date])

3. Total number of sessions / appointments: ___(# scheduled) __ (# attended)

4. Medical information and assessment:

Please explain the initial diagnosis that was the basis for the medical withdrawal:

Please explain the current diagnosis (if any).

Please explain the course of treatment undertaken during the medical withdrawal (including medication, in-patient or out-patient treatments or therapy, etc.). Please also specify the duration as well as whether the person adhered to and succeeded with the treatment plan.

Is continued treatment recommended? If so, please describe in detail (including as to medication(s), physical or mental health treatment, therapies, or rehabilitation, including type and frequency recommended, etc.).

DENISON

Part B: Assessment:

1. Based on your current evaluation, do you believe that the student is now able to meet the expectations of a student and engage in the rigors of academic and campus life? Please explain whether you have any concerns about the student's ability to live safely and independently on campus, manage their self care, or if you believe they present a danger to themselves or others.

2. Please describe any other recommendations for follow-up that you have communicated to the student.

If you require more space to answer the above questions, you may include additional documentation as well as the completed form.

_____ _____

Provider Signature Date

Thank you for your assistance.

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

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