UNION UNIVERSITY
Student Life

Licensed Provider Recommendation for Medical Withdrawal

Part I: Provider information: *All areas required*

Provider Name: _____ Office Phone: (____) ____ - _____

Office Address: _____

_____

Provider Credentials: ☐MD/DO ☐NP/PA ☐Mental Health ☐Other NPI #:_____

Specialty: _____ License #: _____ State of Issue: _____

Part II: Student Information:

Patient's Full Name: _____ Patient's DOB: ____/____/____

Part III: Clinical History: *Please complete all information in detail (attach additional sheets if needed)*

Patient's Diagnosis(es) with ICD-10 and/or DSM codes:

_____

_____

_____

Did the student's acute condition or increased-severity chronic condition qualify as a medical emergency?

Yes No

Provide the date of onset for the acute condition or increased severity of a chronic condition: ____/____/____

Please provide the final date the patient was under your care for the emergency condition: _____

Provide any additional information relevant to your recommendation for medical withdrawal for the patient on office letterhead.

Do you anticipate that the patient will be able to return to campus?: Yes No

If yes, when and under what circumstances?: _____

Part IV: Certification Statement

With my signature below, it is my medical opinion that the student is unable to participate in the academic program and qualifies for a medical withdrawal from the _____ term or semester, 20__ , at Union University. The patient has given me permission to share the included information with Union University and discuss further medical information if needed.

Signature: _____ Stamp: _____ Date: _____