



REQUEST FOR MEDICAL WITHDRAWAL
WELLNESS CENTER
220 PAWTUCKET STREET, UNIVERSITY CROSSING, SUITE 300
LOWELL, MA 01854

phone: 978-934-6800
fax: 978-934-3080
email: Health_Services@uml.edu

To ensure confidentiality and privacy the **student** must complete and sign the Release of Medical Information section before submission of the document to their health care provider. All information will be kept strictly confidential and will be used only for the purpose of evaluating the student's request for withdrawal from school and readiness to return to their academic work. The university reserves the right to impose conditions on return following a medical withdrawal, which will include the submission of additional documentation from the student's health care provider and the student's consent to discuss the student's condition with University clinicians. Upon submission of a Request for Medical Withdrawal, a hold will be placed on the student's SiS account preventing future course registrations and/or attendance. This hold will be removed upon the submission of an appropriate and completed Readiness for Return form. A student who has already registered for courses for the subsequent semester will be required to submit a Readiness for Return form no later than one week prior to the start of that semester or they will be dropped from their courses. Please note that there are no adjustments to tuition or fees after the Add/Drop period.

This information will not become part of the student's academic record or health record but will be retained in a separate administrative file.

I, _____, have read the University of Massachusetts Lowell Purpose, Policy, and Procedure for a Request for Medical Withdrawal and have had the opportunity to have questions answered.

Date

Student Signature

RELEASE OF MEDICAL INFORMATION

Last Name First Name MI SiS ID#

Address

Date of Birth Phone

Term/Year of Medical Withdrawal

Year of Study (Fr, So, Jr, Sr, Grad) Major

Date of last class attendance

I hereby authorize the release of information to the Directors of Health Services and/or Counseling Services at the University of Massachusetts Lowell for the purpose of determining my eligibility for an academic withdrawal due to medical circumstances. This information may include psychiatric care and/or treatment for alcohol and/or substance abuse.

Date

Student Signature

For Administrative use:
<input type="radio"/> Date Received
<input type="radio"/> Approved
<input type="radio"/> Denied
<input type="radio"/> Pending

Student Information

To be completed by medical provider.

Last Name First Name Date of Birth

VERIFICATION FOR MEDICAL WITHDRAWAL (Please complete all sections. Incomplete forms will be returned for further information.)

Diagnose(s)

Diagnostic code(s) (ICD 10 or DSM 5)

Date of Diagnosis Date of Hospitalization Date of Surgery

Current Medication(s)

Currently under treatment? Yes No

Dates of service: Initial visit Last visit Next scheduled visit

Please specify in detail how this problem interferes with the student's academic performance:

	No impairment	Mild impairment	Moderate impairment	Significant impairment	Severe impairment
Ability to attend class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to complete assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to prepare/study for exams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to complete labs, practicums, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work collaboratively with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to navigate a decentralized campus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for your assistance in completing this document. Please provide your contact information. We may need to follow up for additional details or to verify any of the documentation.

Provider's Name License #

Address Phone

City State Zip Code Fax

Date

Provider Signature / Credentials _____

Please return form to: Director, Wellness Center Health Services
220 Pawtucket Street, Suite 300
Lowell, MA 01854