CONFIDENTIAL

Readiness for Return from 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

A student wishing to return to academic participation following a medical withdrawal must provide appropriate medical documentation from a licensed medical or mental health provider who is knowledgeable of the student's health history and has treated the student for the condition necessitating the medical withdrawal. This documentation must indicate that it is appropriate and safe for the student to resume academic coursework at the beginning of a specified semester/term. A Readiness for Return from Medical Withdrawal form must be competed in full and submitted to the Director of Health Services at the address above.

STUDENT INFORMATION

Last Name _____ First Name _____ MI _____

Date of Birth _____ Student ID# _____

Term/Year to Return _____ Term/Year of Medical Withdrawal _____

PROVIDER INFORMATION

Provider Name _____ Phone _____

Address _____ Fax _____

Credentials/License Number _____

CLINICAL HISTORY

Please complete all information required in detail. Additional information may be provided on office letterhead.

Student's diagnos(es) _____

Diagnostic code(s) (ICD 10, DSM 5) _____

Dates of care _____

Date of resolution to a level which does not interfere with the student's academic performance. _____

Please describe how the student's condition(s) has/have resolved or stabilized so as to not interfere with the student's academic performance.

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STUDENT INFORMATION

Last Name | First Name | Date of Birth

Please describe the plan of care developed with the student including medication, treatment/therapy, and follow-up, if needed, to maintain resolution or stability.

_____
_____
_____
_____
_____
_____
_____
_____

Please confirm that the student is able to:

		comments
Attend class	☐	
Complete assignments	☐	
Prepare/study for exams	☐	
Complete labs, practicums, etc.	☐	
Work collaboratively with peers	☐	
Navigate a decentralized campus	☐	

Readiness for Return from Medical Withdrawal

In my professional judgement, my patient / client _____ is
(name of student)
able to return to full academic and co-curricular participation at the University of Massachusetts Lowell as of

_____. This student has given me permission to share the above information with the University of
(date)
Massachusetts Lowell and to discuss their medical information with the Director of Health services or the Director of

Counseling Services at the Wellness Center, if necessary.

Provider name

_____ Date
Provider Signature / Credentials