Confidential

**REQUEST FOR MEDICAL WITHDRAWAL FROM COURSES**

WELLNESS CENTER phone: 978-934-6800

220 PAWTUCKET STREET, UNIVERSITY CROSSING, SUITE 300 fax: 978-934-3080

LOWELL, MA 01854 email: Wellness\_Center@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. 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

**☐ I have attached my Personal Statement**

**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.

For Administrative use:

* Date Received
* Approved
* Denied
* Pending

Date

Student Signature

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Revised 8/2023

**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 |  |  |  |  |  |
| Ability to complete assignments |  |  |  |  |  |
| Ability to prepare/study for exams |  |  |  |  |  |
| Ability to complete labs, practicums, etc. |  |  |  |  |  |
| Ability to work collaboratively with peers |  |  |  |  |  |
| Ability to navigate a decentralized campus |  |  |  |  |  |

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: Wellness Center phone: 978-934-6800

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