PROVIDER REPORT FORM

FORM D

SECTION I: Completed by Student (*Please print or type. Information must be legible*.)

Student Name: _____ Date of Birth: _____ UCF ID: _____

Semester/Year for which medical withdrawal is being sought: _____

How many classes are/were you enrolled in during the above semester? _____

How many of those classes are/were impacted by your medical condition? _____

Reason for medical withdrawal:_____

_____

Dates of hospitalization, if any: _____

Steps you have taken (i.e. counseling, hospitalization, other treatment) to address/resolve your concerns for withdrawal:

_____

I hereby certify that my condition was of such severity that I was unable to carry out academic and employment activities for the remainder of the term. ☐ YES ☐ NO

Student's Signature: _____ Date: _____

****

SECTION II: Completed by Physician/Treatment Provider (*Please print or type. Information must be legible. Your clear and precise response is important and may affect the student's current and future enrollment at the University. Processing of student's request will be delayed if this section is not completed*.)

Provider Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

A. Your Treatment of the Student

☐ Medical ☐ Psychological ☐ Psychiatric ☐ Alcohol/Drug ☐ N/A

Dates seen during the medical withdrawal term: (From) _____ (To) _____

Total # of sessions/appointments during the medical withdrawal term: _____

Diagnosis: _____

Pre-existing condition? ☐ YES ☐ NO

If yes, what changed in the condition during this semester that resulted in being unable to complete the courses?

_____

Medications (If yes, please specify): _____

Dates of hospitalization, if any: _____

Current Status: ☐ Stable ☐ Unstable

☐ Requires ongoing care ☐ Requires periodic follow-up

Prognosis: _____

Will you continue to provide services to the student? ☐ YES ☐ NO

If relevant, to whom will the student's care be transferred while on medical withdrawal?

_____

B. Criteria for Medical Withdrawal

It is expected that all providers who submit documentation on behalf of a student pursuing a medical withdrawal will have been the student's treatment provider during the period of disabling illness. The documentation provided should be sufficient to substantiate the severity of the student's condition during the semester in which medical withdrawal is being sought**.** The impairment must reflect a severity level that substantially interfered with activities of daily living such that the student was unable to carry out academic and employment activities or complete all courses for the remainder of the term.

Medical withdrawals can only be approved in cases where the student is unable to finish the term. A medical withdrawal is usually for all classes in the term. If a student is requesting a selective withdrawal, the student must have documentation explaining how a select number of courses are affected by the medical condition.

NOTE: If a medical withdrawal is approved for acute psychiatric/mental health reasons or communicable disease, it is typically expected that the student not enroll at the University in the semester immediately following, and will use that time to obtain treatment to address or resolve the condition necessitating the withdrawal.

C. Your Assessment of the Student's Condition

Please provide a written statement describing the severity of the student's condition and how it affected his/her academic functioning and ability to maintain employment. If the condition is pre-existing, please explain how it specifically impacted the student during the semester in question.

_____

_____

_____

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_____

D. CERTIFICATION

I hereby certify that the above-named student's condition reflected a severity level which substantially interfered with her/ his activities of daily living such that she/he was unable to carry out academic and employment activities or complete all courses for the remainder of the term.

☐ **YES** ☐ **NO** ☐ **Unable to Certify Due to Insufficient Information***

* If you are unable to certify the required severity of the condition, you may still provide any relevant information.

Signature of Provider: _____ **Date:** _____

Supervisor Signature *(if applicable)*: _____ Date: _____

(Interns who are completing this form should have their licensed supervisor co-sign.)

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Please forward this original form to the Academic Services office at the address below.

Faxes will not be accepted in lieu of the original form.

This form will not be accepted if hand-carried or mailed in by the student.

Thank you.

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