



STUDENT HEALTH SERVICES

The University of Alabama at Birmingham

Provider Medical Withdrawal Recommendation Form

Part I: Provider Information

Please complete **all** information required.

Provider Name: _____ Provider Phone: _____

Provider Credentials (*please select*)

MD/DO, Specialty: _____

Nurse Practitioner, Specialty: _____

Physician's Assistant, Specialty: _____

Part II: Student Information

Patient's Full Name: _____

Patient's Date of Birth: _____ Patient's Student ID Number (B0#) (if known): _____

Part III: Clinical History

Please complete all information required in detail (attached additional information if needed).

Patient's Diagnoses with ICD-10 and/or DSM codes:

Describe how or why the condition is interfering or previously interfered with the patient's academic performance, safety, or wellbeing at The University of Alabama at Birmingham: _____

Provide the date of onset for an acute condition, or the date of worsening of a chronic condition, with a level of severity interfering with the patient's academic performance, safety or wellbeing at The University of Alabama at Birmingham: _____

Please provide the date(s) the patient was under your care for these diagnoses: _____

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

If appropriate at this time, do you anticipate that the patient would be able to return to campus? _____

If yes, when and under what circumstances? _____

Part IV: Certification Statement

With my signature below, I provide my recommendation for medical withdrawal from the _____ term or semester, 20____, at The University of Alabama at Birmingham. The patient has given me permission to share the foregoing information with The University of Alabama at Birmingham officials and discuss their medical information with a physician at UAB Student Health Services if needed.

Signature: _____ Stamp: _____ Date: _____