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, NP, or PA; Specialty: _____
Mental Health Professional, Credentials:_____

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:_____