Medical Withdrawal Request to Return-Healthcare Provider Report

Purpose: this form is used when a student wishes to return to Marquette after an official medical withdrawal from the University and is completed by the student's healthcare provider. "Healthcare Provider" means Licensed Healthcare Provider (e.g. MD, DO, Psychologist, Licensed Clinical Social Worker, etc.).

Student Instructions:

1. Complete Section 1 of this form using a computer.
2. Print the form using the 'Print Form' button.
   a. **a handwritten form will not be accepted.**
   b. an incomplete form will not be processed and will be returned to you for completion.
3. Sign the form in Section 2; a digital signature is **not** acceptable.
4. Submit this form to your healthcare provider at least 6 weeks prior to your planned return to the University.

Note: *both the **Medical Withdrawal-Return to Marquette University form** and the Request for Readmission form must be completed and submitted in order for your return request to be considered.*

Healthcare Provider Instructions:

1. Complete Sections 3 and 4 of this form.
2. Sign the form in Section 5.
3. Return the original form via one of the methods listed at the bottom of this form within 4 weeks of the student's planned return to the University.

Note:

a. An unsigned form with not be processed.
b. This form must come directly from the Healthcare Provider (not the student) or it will not be accepted.

Section 1: Student Information

Name
Last name, First name, Middle name _____ MUID _____

Mailing Address
street, city, state, zip code _____

Phone _____ Email _____ @marquette.edu

Date of expected return to Marquette *MM/DD/YYYY* _____ Print Form

Section 2: Student Statement and signature:

I certify that the information provided above is true and correct.

Student's Signature _____ Date _____

Section 3: Licensed Healthcare Provider Information

Name _____ License Number and State _____

Licensed as _____ Clinic/Hospital Name _____

Mailing Address _____

Phone _____ Fax _____

Section 4: Licensed Health Care Provider Report

Please use the back of this page or attach additional documentation if you wish to expand on your responses to the questions above and/or to record any other comments or observations you may wish to make regarding the student and his/her ability to function safely, stably, and successfully as a full-time student at this time.

Date of first treatment contact _____ Date of most recent treatment contact _____

Diagnosis for which the student is being treated *(i.e. description)* _____

MARQUETTE UNIVERSITY

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Section 4: Licensed Health Care Provider Report ***(con't)***

Please provide your professional judgment in response to the following questions regarding the above named student.

☐ Yes ☐ No Has there been a substantial improvement of the student's original medical/psychological condition?

If yes, please check all of the following that you have observed a marked reduction of in this student:

☐ Number of symptoms ☐ Severity of symptoms ☐ Persistence of symptoms ☐ Functional impairment ☐ Subjective level of client distress

For how long has the improved condition been maintained? _____

If medical leave was due to a psychological reason, has there been a substantial reduction of any of the following safety related behaviors the student may have been engaging in?

☐ Yes ☐ No ☐ N/A Self injurious behaviors

☐ Yes ☐ No ☐ N/A Substance abuse behaviors

☐ Yes ☐ No ☐ N/A Failure to maintain weight at minimum of 85% of Ideal Body Weight for height

☐ Yes ☐ No ☐ N/A Food bingeing

☐ Yes ☐ No ☐ N/A Food purging or other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.)

☐ Yes ☐ No ☐ N/A Disturbing behavior that is disruptive to the campus community

☐ Yes ☐ No ☐ N/A Other: _____

☐ Yes ☐ No ☐ N/A Has the substantial reduction in safety related behaviors been maintained stably for at least four consecutive months?

What evidence has been demonstrated to suggest that the student has increased ability to manage academic life and live independently?

_____

What responsibilities has the student maintained during their time away from the University that suggets he/she is ready to return to the rigors of academia? (e.g. employment, volunteerism, etc.)

_____

☐ Yes ☐ No ☐ Unsure In your professional judgment, do you think the student can manage a full course load (12 or more credits or 7 credits for a graduate student)?

☐ Yes ☐ No ☐ Unsure If "No" or "Unsure" to the above, do you think the student can manage a reduced course load (fewer than 12 credits or 7 credits for a graduate student)?

Please check the following activities you believe the student is presently capable of managing:

☐ Attending a lecture of 2 hours in length ☐ Concentrating on and grasping complex read material ☐ Spending hours in study ☐ Organizing and writing papers ☐ Balancing academic demands with extracurricular activities

What are your recommendations for continued treatment?

_____

☐ Yes ☐ No Will the student have these recommendations in place at time of potential return to campus?

☐ Yes ☐ No ☐ N/A (student is not a dependent) To your knowledge, are the parents and/or legal guardian(s) of the patient aware of the problem(s) for which you have provided treatment?

Other comments:

_____

Section 5: Healthcare Provider's signature

Healthcare Provider's Signature: _____ Date _____