Texas Southern University

REQUEST FOR MEDICAL WITHDRAWAL -HEALTHCARE PROVIDER CONSENT

This is a request to certify a serious health condition that may prohibit a student from continuing his/her education. The student is required to have the form completed by healthcare provider who is treating the student for a specific condition. Section I of this request is to be completed by the student. Section II is to be completed by the treating healthcare provider. Healthcare Providers include: MD, DO, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Psychologist.

Section I – (To be completed by the student)

Student's name: ____

Student's T-number: _____________ / Birthdate___________________

Student's address and Phone number: ___________________________

Student's Email Address: _____________________________________

Last date of attendance: _____________________________________

Student's explanation for withdrawal:

____

____

____

____(Signature/Date)

I agree to have this form completed by my treating healthcare provider and to have the information released to Texas Southern University.

__________________________(Signature/Date)

Once Sections I, II, and Part A have been completed, I will upload it to https://tsu.medicatconnect.com for review by the Medical Withdrawal Committee.

_________________________(Signature/Date)

If this request is approved, I understand I must receive medical clearance to return to the university.

_________________________(Signature/Date)

Section II – Health Care Provider

Your patient has requested a Medical Withdrawal from Texas Southern University for a health condition (injury, illness, impairment) that incapacitates the student and supports the student's written statement in Section I of this form. If approved, the student will be withdrawn from the university.

Health Care Provider's name:____

Health Care Provider's business address: ______________________________

Health Care Provider's email address: ________________________________

License Number: ___________________________________

Phone: ____________________ Fax: ________________________________

PART A: Healthcare Provider Consent

Limit your response to the health condition the student is requesting a withdrawal. Based on your knowledge, experience, and examination or assessment of the patient, please provide information to support the withdrawal request.

Date or approximate date condition occurred: ______________

Estimate of how long the condition will last: ____________________

Check all that apply:

___ The patient is expected to be or is currently in the hospital from ____ to ____.

___ Patient is expected to be incapacitated from ___________ to __________.

___ Patient requires additional recovery time from __________ to _________.

___ Due to a condition, it is medically necessary for the patient to be absent from school from ________ to ______________.

___ None of these apply. Please state why this student should receive a medical withdrawal from the university:
____
____
____

Signature of Health Care Provider______________________________/__________(Date)