Office of the Dean of Students
1120 15th Street, Summerville-BELL 101
Augusta, GA 30912
(phone) 706-737-1411
Email: deanofstudents@augusta.edu

Licensed Provider Recommendation for Medical Withdrawal

Student/Patient Information:
Patient's Full Name: _____ Date of birth: _____AU ID: _____

Student Attestation:
I acknowledge that all medical/psychological information provided by me and/or my health care provider at my request becomes part of my confidential student record which is protected by FERPA but is not subject to HIPAA. This information will only be shared with parties authorized by the Medical Withdrawal Committee. By signing below, I am granting permission for the Medical Withdrawal Committee and/or designees, to obtain and review any and all documentation submitted by my health care provider, including verbal and/or written communication for the purpose of reviewing this petition. ***By signing below, I am also indicating that I've discussed my medical/psychological conditions with my provider.***
Student Signature: _____ Date: _____

Provider Information:
Name (print): _____ Phone: _____
Name of Practice: _____ Address: _____
Provider Credentials: (select one):
□ MD/DO (specialty): _____ □ Nurse Practitioner: □ Physician Assistant □ Mental Health Professional: (please specify): _____
License Number: _____ State of issue: _____

Patient's Clinical Information:
Patient's Diagnoses:
_____ □ current ongoing diagnosis □ previous diagnosis
_____ □ current ongoing diagnosis □ previous diagnosis
_____ □ current ongoing diagnosis □ previous diagnosis

How did you make the diagnosis(es)? What tools or methods were used to evaluate the student's symptoms?
_____

Please describe the symptoms of the stated diagnosis(es) this student experienced? _____
_____

Describe how or why your patient's condition is interfering or previously interfered with his/her academic performance, safety or wellbeing at Augusta University. _____
_____

Your assessment and treatment of the student/patient: ___ Medical in nature ___ Psychological in Nature
____Drug/alcohol concerns ____ Other: _____

Date of symptom(s) onset for above condition(s): _____

Date when patient was first unable to attend school, due to above symptoms (if known): _____

Last date patient was treated by you: _____

Total number of sessions/appointment: Scheduled: _____ Attended: _____

Prognosis: ____ Excellent _____ Good ____Fair ____ Poor

Will you continue to provide services for the student? ____ Yes ____ No If no, to whom will the student's care be transferred? _____

Based on your assessment, does this student's current medical/psychological condition prevent, not simply make it more difficult for him or her to be able to perform behaviors necessary for participation in a college education at this time?

___Yes, the student is experiencing significant functional impairment in the following areas (Check all that apply)

____ Unable to Attend Classes
____ Unable to Navigate Campus
____ Poses Danger to Self
_____ Poses Danger to Others
_____ Cognitive Impairment
_____ Other: _____

Please provide brief explanation: _____

_____

___ No

___ No, but will need accommodations (please describe): _____

_____

When do you believe the student will be well enough to return to AU? _____

Based on your assessment, do you believe your patient needs a full medical withdrawal from all courses_____.

Provider Attestation:

With my signature below, I provide my recommendation for medical withdrawal from the _____ semester. My patient has given me permission to share the foregoing information with Augusta University officials.

Provider Signature: _____ Date:_____