



## MEDICAL WITHDRAWAL Student Information – Please Read Carefully

A medical withdrawal is complete withdrawal from all University classes in a designated semester and year. As a student at Northern Illinois University, you may be eligible for a medical withdrawal if you experience a serious medical condition that affects your class attendance and/or participation during the semester/year designated. A request for a medical withdrawal requires Health Services to review medical documentation before making recommendation (not an approval), to the college, who will make the final decision for approval and academic status.

1. You must contact the Advising Dean of your Academic College (see below) regarding your intentions to withdraw from the university.

Business-Barsema Hall  
College of Law (undergrad)-Swen Parson  
Education-Graham Hall  
Engineering-Engineering Building  
Health & Human Sciences-McMurry Hall

Liberal Arts & Science-Zulauf Hall  
Visual & Performing Arts-Music Building  
Undecided, Academic Advising Center-Adams Hall  
Graduate School-Adams Hall 210

2. If you are in a university residence hall, please notify NIU Housing & Dining office for arrangements to move out.
3. A completed and witnessed *Student Application and Authorization for Medical Withdrawal* (page 2) must be submitted to Health Services Administration Office, Room 422.
4. It is your responsibility to contact your healthcare provider/s asking them to submit the *Licensed Provider Documentation Form for a Medical Withdrawal* (page 3) to Health Services documenting the serious medical condition that affected your class attendance and/or participation during the designated semester/year. The original, signed documents must be received by Health Services before a medical review begins. Please do NOT fax any information to Health Services. This document or information from it will not be disclosed to anyone outside of Health Services without authorization for *Release of Information* signed by you.
5. The Health Services administrative physician will review all medical documentation submitted by a medical provider/s in support of your request of a withdrawal from the university for medical reasons. Medical review will be completed in approximately 5 to 7 working days after medical information is received by Health Services. The Student Affairs Office and your academic college will be notified of the “*Recommendation*” and you (the student) will receive a copy of the memo as well. Your academic college determines the final outcome of your medical request and academic status. Please contact them after you have received the copy of the memo to verify the approval or denial of your request.
6. If you were treated for your medical condition by Health Services medical staff during the designated semester and year, you may authorize the practitioner(s) to submit medical documentation in support of your application for a medical withdrawal. A Health Services *Authorization for Release of Confidential Information for Administrative Purpose* (page 4) must be completed.
7. If the medical information provided is not sufficient, Health Services will notify you of this determination. You may submit additional, new medical information for the administrative physician review.

Please contact NIU Health Services Administration Office if you have any questions: 815-753-1316 or 815-753-0859, Monday – Friday, 8 AM – 4:30 PM.



STUDENT APPLICATION AND AUTHORIZATION  
MEDICAL WITHDRAWAL FROM UNIVERSITY

I am seeking a medical withdrawal from the University for the semester and year identified below.

Name \_\_\_\_\_ Z-ID# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Current daytime telephone number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Semester (circle one)    Fall    Spring    Summer    Interim    Year \_\_\_\_\_

Please check one box:     Undergraduate Student     Graduate Student

**I HEREBY REQUEST AND AUTHORIZE** the administrative physician or physician designee of Health Services, Northern Illinois University, DeKalb, IL 60115:

1. To verify the presence of an acute and/or prolonged, severe medical condition during the above semester to be forwarded to the Advising Dean, College of: \_\_\_\_\_
2. *(Optional)* The person/s listed below has my permission to discuss the status of my request for a University medial withdrawal (e.g., parent, spouse, etc.):

\_\_\_\_\_  
(Name of person and relationship to applicant)

I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure and that my refusal to authorize disclosure of this information will result in the following consequences: Unexcused academic absence.

I may revoke this authorization at any time by written notification to Health Services. However, I understand revocation cannot be retroactive. I absolve and agree to hold harmless the individual or agency identified above, and the NIU Board of Trustees, together with its officers and employees, from any legal liability, claims or damages which may arise from disclosure of this information. Unless revoked, this consent is valid until the request is completely processed.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Please return completed form to the address above.



**PROVIDER DOCUMENTATION FORM – MEDICAL WITHDRAWAL**

Student's Full Name \_\_\_\_\_ Z- ID# \_\_\_\_\_

Semester and Year \_\_\_\_\_ DOB \_\_\_\_\_

**Please type or print the requested information in the space provided below and return this form with original signature to the above address. Do NOT Fax.**

<p><b>1. Diagnosis and code of the severe medical condition that significantly impaired or obstructed student's class attendance or participation during the above semester.</b></p>	
<p><b>2. For the above condition, indicate the</b></p> <ul style="list-style-type: none"> <li>▪ <b>date(s) of evaluation and/or treatment during the above semester;</b></li> <li>▪ <b>location of evaluation and/or treatment (e.g., office, hospital OP, hospital IP, etc.); and</b></li> <li>▪ <b>nature or purpose of each evaluation and/or treatment provided.</b></li> </ul>	
<p><b>3. Provide the specific medical findings, restrictions and/or other <u>objective</u> data that document how student's class attendance or participation was significantly impaired or obstructed during the above semester.</b></p>	

\_\_\_\_\_  
Signature of Attending Licensed Healthcare Provider and Title Date

\_\_\_\_\_  
Printed Name, Business Address, Telephone Number

COMPLETE THIS FORM ONLY IF SEEN BY AN NIU HEALTH SERVICES PRACTITIONER



NORTHERN ILLINOIS UNIVERSITY

HEALTH SERVICES
Administration Office, Room 422
Northern Illinois University
DeKalb, IL 60115
(815) 753-1316

Authorization for Release of Confidential Health Information for Administrative Purposes

Name: (Last) (First)

Z-ID# / Date of Birth / / Phone# ( )

Address City State Zip

I, the above named patient, authorize NIU Health Services to release my confidential health information to the Health Services Administrative Physician for the purpose of administrative review of my request for a Medical Withdrawal, Course Load Reduction or Special Housing/Dining Arrangement at Northern Illinois University.

Please list the names of the NIU Health Services Practitioners and staff authorized by this release:

Please indicate information and dates to be released:

- Immunizations Lab results
Office visit notes X-ray results or film
Other

Diagnosis of Mental Health, Alcohol and Substance Abuse and Infectious Disease (AIDS/HIV) are NOT included in a general release. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require diagnosis of Mental Health, Alcohol and Substance Abuse and Infectious Disease information specifically indicated. Please indicate information and specify dates to be released and initial.

- Mental Health Alcohol and Substance Abuse Infectious Disease

I understand that I have the right to inspect and/or obtain a copy, for an appropriate fee, of the information prior to disclosure. I may revoke this authorization at any time, except to the extent that action has already been taken, by submitting a written revocation to Northern Illinois University, Health Services. If I refuse to sign this authorization, my medical record/information will not be released. This authorization will be considered valid for a 90-day period (expiration date / / ) following the date of signature unless otherwise specified here. I absolve the individual or agency identified above and the Board of Trustees of Northern Illinois University together with its officers and employees from any legal liability which may arise from the disclosure of this information.

Patient Signature: Date:

Witness Signature: Date:

Print Name:

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without patient authorization for such disclosure.

Processed by Date Processed