MEDICAL WITHDRAWAL
Information for Undergraduate Students

As an undergraduate student at Northern Illinois University, you may be eligible for a university withdrawal for medical reasons if you experience a serious medical condition that obstructs your class attendance or participation during a designated semester. A request for a medical withdrawal requires Health Services review of pertinent medical documentation submitted by your healthcare provider. The information below is intended to assist you with a request for a medical withdrawal and to avoid delays in the medical review process. Additional information about university withdrawals can be found at www.stuaff.niu.edu/stuaff/studentlifepolicies.

- You must contact the Advising Dean for your academic college and the office of the Vice President for Student Affairs regarding a request for a university withdrawal for medical reasons.

- A completed Undergraduate Student Application and Authorization – Medical Withdrawal (below) must be submitted to Health Services Administration, Health Service Building, Room 422.

- You must arrange for your healthcare provider to submit medical information to Health Services to document the serious medical condition that obstructed your class attendance or participation during the designated semester. Two documents below, e.g., Licensed Provider Information – Medical Withdrawal and Licensed Provider Documentation Form – Medical Withdrawal, must be used for this purpose. Original, signed documents must be received by Health Services before medical review can begin. Faxed or photocopied documents will not be accepted.

- If you were treated for your medical condition by Health Services medical staff during the designated semester, 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 (attached at the end of this document) must be completed.

- The Health Services administrative physician will review all medical documentation that has been submitted in support of your request for a medical withdrawal. Medical review will be completed approximately one week following receipt by Health Services of your medical information.

- If the medical information documents a serious medical condition that obstructed your class attendance or participation during the designated semester, a recommendation in favor of a medical withdrawal will be forwarded to the Advising Dean who will make the final decision regarding your request.

- If the medical information does not document a serious medical condition that obstructed your class attendance or participation, Health Services will notify you by letter of this determination. You may submit additional, new medical information for administrative physician review.

Please call Health Services Administration (815-753-1316 or 815-753-1314), 8 AM – 4:30 PM, Monday – Friday, with any questions pertaining to the medical review process.
UNDERGRADUATE STUDENT APPLICATION AND AUTHORIZATION
MEDICAL WITHDRAWAL

I am seeking a university withdrawal for medical reasons for the semester identified below.

Name ____________________________________________ SSN __________________
Address __________________________________________
City ____________________________________________ State _________ Zip Code _________
Current daytime telephone number ______________________ Date of Birth _________
Semester (circle one) Fall  Spring  Summer  Interim  Year _______________

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 the Advising Dean, College of: ____________________________

2. (Optional) To discuss the status of my request for a medical withdrawal with the following (e.g., parent, spouse, etc.):

_____________________________________________________________________

(Name 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

Return completed form to Health Services Administration, Health Service Building, Room 422.
“Provider” means Licensed Healthcare Provider (e.g., MD, DO, Clinical Psychologist, etc.).

A student at Northern Illinois University (NIU) has applied for a university withdrawal for medical reasons based on the presence of a serious medical condition that obstructed his/her class attendance or participation during a designated semester. A medical withdrawal requires review of the student’s pertinent medical information by the administrative physician at NIU Health Services. The student has identified your office as a source of medical information to support his/her request.

- Pertinent medical information for this process includes written provider documentation of objective data (e.g., evaluation results, diagnosis, therapy, treatment recommendations, or other objective information) that confirms the presence of a severe medical condition that obstructed the student’s class attendance or participation during the designated semester.

- The student is solely responsible for arranging the release of pertinent medical information from your office to NIU Health Services to support his/her application for a medical withdrawal.

- Your patient will ask you to submit a completed Licensed Provider Documentation Form – Medical Withdrawal to Health Services Administration, Health Service Building, Room 422. Please note the following:

  An original, signed licensed provider documentation form must be received by Health Services. Faxed or photocopied documents will not be accepted.

  Please return the original licensed provider documentation form only to Health Services. No other NIU office participates in reviewing the student’s medical information.

  Only the information indicated on the licensed provider documentation form is requested at this time. Please do not send copies of your patient’s medical records to Health Services or to any other NIU office.

This medical documentation is being requested for Health Services administrative purposes only, not for treatment, payment or other operational purpose. The documentation will be maintained confidentially at Health Services in a secure location separate from the student’s medical record for a period of ten years from the date of the student’s last NIU enrollment and then destroyed.

Please call Health Services Administration (815-753-1316 or 815-753-1314), 8 AM - 4:30 PM, Monday – Friday, with any questions pertaining to the medical review process.

Thank you.
LICENSED PROVIDER DOCUMENTATION FORM – MEDICAL WITHDRAWAL

Student's Full Name ___________________________________________ SSN ____________________

Semester and Year ___________________________________________ DOB _________________

See Licensed Provider Information – Medical Withdrawal at www.niu.edu/uhs/pdfs/WD-UG.pdf.

Please type or print the requested information in the space indicated and return this form to Health Services Administration, Health Service Building, Room 422, DeKalb, IL 60115. Thank you.

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<td>1. Diagnosis and code of the severe medical condition that significantly impaired or obstructed student's class attendance or participation during the above semester.</td>
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<td>2. For the above condition, indicate the:</td>
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<td>▪ date(s) of evaluation and/or treatment during the above semester,</td>
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<td>▪ location of evaluation and/or treatment (e.g., office, hospital OP, hospital IP, etc.), and</td>
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<td>▪ nature or purpose of each evaluation and/or treatment provided.</td>
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<td>3. Indicate the specific medical findings, restrictions and/or other objective data that document how student's class attendance or participation was significantly impaired or obstructed during the above semester.</td>
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Signature of Attending Licensed Healthcare Provider and Title ___________________________ Date ___________________________

Printed Name, Business Address, Telephone Number ___________________________
Authorization for Release of Confidential Health Information for Administrative Purpose

Name: (Last) (First)  
SSN / / 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:  

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.

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