Application for Medical Withdrawal

University of Southern Indiana
Center for Exploring Majors
8600 University Blvd • Evansville, IN 47712
Education Center, Room 1142
812-465-1606 • Fax 812-461-5367

NOTE: Withdrawing from classes, for a serious medical condition (physical or psychological) may impact your health insurance and may negatively impact your eligibility for federal and state financial assistance. We strongly recommend that all financial assistance recipients consult with the USI Student Financial Assistance Office before submitting a request for a medical withdrawal. We also strongly recommend that you contact your health insurance provider before submitting a request for a medical withdrawal.

Submit this form to the Cener for Exploring Majors (Education Center, Room 1142):

1. *After this Application for Medical Withdrawal is received, the Center for Exploring Majors will contact faculty members affected by the withdrawal.*
2. *Each faculty member will be given adequate time to respond.*
3. *The withdrawal request and all faculty members' input will be forwarded to the Administrative Appeals Committee for final disposition.*

IMPORTANT NOTE: Tuition refund policy for medical withdrawals can be found at https://www.usi.edu/registrar/schedule-changes/medical-withdrawal/ Requests for medical withdrawals prior to the current term must be submitted within one term after the end of the academic term for which the medical withdrawal is considered. The summer sessions are included as a term. For example:

Medical Withdrawal Requested for:	**Must be received by:**
Fall Semester	*April 30th of the following year*
Spring Semester	*September 30th of the current year*
Summer Sessions	*November 30th of the current year*

The following section is to be completed by the student

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I acknowledge that I am requesting a medical withdrawal for the semester(s) indicated below:

Student signature_____

Please notate the semester or semesters and year for which you are requesting a medical withdrawal:

Fall _____ (year) Spring _____ (year) Summer (please indicate session) _____ (year)

Have you had a previous Medical Withdrawal? ☐Yes ☐No List previous term (s): _____

Is this a second Medical Withdrawal request for a prior Medical Withdrawal? ☐Yes ☐No
Note: Second Medical Withdrawal requests must be received within 90 days from the date on your first Medical Withdrawal denial letter.

Should your request for a refund be approved and you have a student loan, do you authorize Student Financial Assistance to refund your loan program? ☐Yes ☐No ☐Not Applicable

A request to withdraw will only be granted for the entire schedule of courses taken during the current term except in extraordinary circumstances, i.e. a broken limb in a physical education course.

Future Term Enrollment: Students who have been medically withdrawn from the university are required to have their health care provider complete a Release to Return to the University form. (https://www.usi.edu/media/1720149/releasetoreturn.pdf) Students choosing not to return after a medical withdrawal are responsible for withdrawing themselves from future registration.

Name of Student (please print):_____

Student ID Number: _____

Mailing Address: _____

Phone Number:_____ Email Address:_____

CONSENT TO RELEASE MEDICAL RECORDS

The University of Southern Indiana requires this information before processing an application for medical withdrawal.

I,_____(STUDENT NAME), hereby authorize the University of Southern Indiana to use and disclose my individually identifiable health information, medical records and other information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164 for the purposes of reviewing my request for withdrawal from the semester/term for medical reasons.

I authorize the disclosure of any information governed by HIPAA to be provided to the Administrative Appeals Committee, Registrar's Office, Dean of Students Office, and any other University personnel involved in the process of reviewing my request for withdrawal.

This authority given to the University of Southern Indiana shall supersede any prior agreement that I may have made with my medical providers to restrict access to or disclosure of my individually identifiable health information. The authority given herein has no expiration date and shall expire only in the event that I revoke this Release in writing and deliver it to the Center for Exploring Majors.

I acknowledge that if I have been withdrawn from the University due to a serious physical or psychological condition, I will need clearance from my terminally degreed licensed healthcare provider to resume studies before I can be reinstated.

Student Signature:_____Date: _____

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The following section is to be completed by the terminally degreed licensed healthcare provider ONLY

Period during which patient was under care for condition that caused student to file application for medical withdrawal:

From: _____ To: _____

Semester and year for which you are recommending a medical withdrawal for your patient:
Fall ____ (year) Spring____ (year) Summer (I, II, or III and year) _____

The Administrative Appeals committee will not grant a request to withdraw from a single class absent extraordinary circumstances. All withdrawals must be for the entire schedule of courses taken during the current term except in extraordinary circumstances, i.e. a broken limb in a physical education course. Because of his/her physical or psychological condition, my patient is/was unable to continue classes and wishes to withdraw from the following (check only one):

CURRENT TERM		PAST TERM
All classes	A portion of my class schedule (extraordinary circumstances only) (List classes below).	All classes
Course 1:		
Course 2:		
Course 3:		

Contact Information for terminally degreed licensed healthcare provider (Doctor, Psychologist, etc.):

Full Name (please print):_____

Mailing Address: _____

Phone Number:_____Fax Number: _____

ATTENTION: Please attach a short explanation of the patient's condition and its impact on his/her ability to complete their course requirements for the semester indicated. Please indicate whether or not you recommend a medical withdrawal for this student/patient based on his/her physical or psychological condition. This explanation must be on prescription form or office letterhead if no prescription form and include your original signature.

1. I certify that all information provided is true, correct, and without personal bias.

Terminally Degreed Licensed Healthcare Provider Printed Name: _____

Terminally Degreed Licensed Healthcare Provider Signature: _____ Date: _____