Documentation for Medical Withdrawal
Office of the Dean of Students
The University of the South

Part 1: To be completed by the student

Date: _____ Name: _____ Banner ID: _____

Permanent Address: _____

Phone Number: _____

Reason for request for a medical withdrawal:

Part 2: This form is to be completed only by the treating physician, psychiatrist, licensed psychologist and/or other licensed mental health professional.

The student named above is seeking to take a medical withdrawal from the University in order to pursue treatment. The University considers a medical leave a last resort as it results in loss of course credit. In making a recommendation, it is helpful for you to understand some about the College and its environment and resources. Sewanee is a residential, rural college with limited access to health care. Information about the scope of care available at the University Wellness Center can be found by navigating the Sewanee webpage, www.sewanee.edu, and following the path > Student Life > University Wellness Center.

Name: Provider License Number:

Business Address:

Phone Number: Email address:

Did you provide treatment for the named student? Yes No

How many treatment sessions have you provided for the student, relating to the reason for this medical withdrawal?

When did treatment commence and conclude? Is it ongoing?

Has the student been following (or has the student completed) treatment as prescribed?

Diagnosis of the medical condition that significantly impaired or affected the student's class attendance or participation during the semester:

Have you referred the student for continuing treatment? If yes, please indicate the name and contact information of the individual or agency.

What would continuing treatment for this student entail?

If you referred the student for continuing treatment, do you believe he/she would be able to function appropriately as a student at this College without continued treatment?

Do you consider that the student presently or in the reasonably foreseeable future may be a threat to his/her own life or the lives of others?

Do you think the student is capable of carrying a full academic load (4 classes)?

Is there any additional information you would like to provide that is helpful to the consideration of a medical withdrawal?

Signature of treating medical professional_____Date: _____

Office stamp: (If stamp is unavailable, please supply written verification on letterhead or prescription paper.)

Please return this form via mail to the Office of the Dean of Students, 735 University Ave., Sewanee, TN 37383; email to dstudent@sewanee.edu; or fax to 931-598-1803.