SEWANEE
THE UNIVERSITY OF THE SOUTH

Medical Documentation for Reinstatement Application

Office of the Dean of Students
The University of the South

Print off the subsequent pages:

- The questionnaire to be completed by your healthcare provider;
- The CONSENT TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION FOR REINSTATEMENT (give this to your healthcare provider so that they can communicate with us);
- The CONSENT FOR UNIVERSITY WELLNESS CENTER TO RELEASE AND OBTAIN CONFIDENTIAL HEALTHCARE INFORMATION FOR REINSTATEMENT (include this with the questionnaire below so Health Services can communicate with your healthcare provider).

Part 1: To be completed by the student

Date: _____ Name: _____ Banner ID: _____

Permanent Address: _____

City State, ZIP: _____ Phone Number: _____

Preferred email (please print): _____

General reason and date for medical withdrawal: _____

_____

Part 2 (below) is to be completed by your healthcare provider.

Part 2: To be completed by your healthcare provider (e.g., your treating physician, psychiatrist, licensed psychologist, and/or other licensed mental health professional)

Having received treatment, the student named above is seeking to return from a medical withdrawal from the University of the South. Please offer your evaluation of the student's current medical status, focusing on the student's likely ability to succeed in a rigorous academic environment. It may be 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

PLEASE FEEL FREE TO ADD ADDITIONAL PAGES AS NECESSARY.

How many treatment sessions did you provide for the student, relating to the reason for the medical withdrawal? Please provide dates, especially of the first and most recent sessions, and please indicate if treatment is ongoing.

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

Please provide a brief summary of the treatment that you provided, including specific treatment goals, interventions, and skill development.

Have you referred the student for continuing treatment? If yes, please outline the basic plan for continuing treatment and indicate the name and contact information of the individual or agency. Do you consider such continuing treatment *required* or *recommended*? That is, do you believe the student would be able to function appropriately without continued treatment?

Please offer details of the student's relapse prevention plan.

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)? If not, why not?

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

For applicants whose separation from The University of the South involved reasons related to health

SEWANEE
THE UNIVERSITY OF THE SOUTH

CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION FOR REINSTATEMENT

Office of the Dean of Students (931) 598-1229

To the Student: Submit this completed form directly to each health care provider or facility responding to the health care concern that led to withdrawal, with directions to provide the identified information to the appropriate University office. (Please also give your health care provider a copy of the next page with its specific expectations for proper documentation.)

Student's name _____
Last First Middle

Social Security Number _____ **Date of Birth** _____

Your Address _____
Street

_____
City State Zip Country

Day Phone _____ Other phone _____ E-mail Address _____

Health Care Provider /Facility Information:

Name _____

Business Address _____

_____
City State Zip Country

Phone _____ Fax _____ E-mail Address _____

Disclosure is to be made to
Director, University Wellness Center
The University of the South
735 University Avenue
Sewanee, Tennessee 37383-1000
Phone: (931) 598-1270
Fax: (931) 598-1746

Information or records authorized for release (select one or more as appropriate):

☐ Attendance/Participation ☐ Assessments ☐ Progress Notes
☐ Disabilities/Accommodations ☐ Discharge/Treatment Summary ☐ Recommendations/Treatment Plans
☐ Verbal Consults ☐ All Clinical Records/Information (I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or HIV information, and I expressly consent to the release of the information.)

☐ Other: _____

As the person signing this consent, I understand that I am giving my permission to the above-named health care provider for disclosure of requested confidential health care information and/or records to health care providers at The University of the South. The purpose of disclosing this information and/or records is to assist in determining my readiness to return to The University of the South as a full-time student after a withdrawal for medical or psychological reasons. I also give permission for consultation between health care providers, which may be required to clarify any information and/or records that are disclosed. I understand that the health care providers at The University of the South will make a recommendation regarding my application for reinstatement to the committee on reinstatement based on this confidential health care information, as well as any requirements for ongoing care on my return to The University of the South. This information and/or records will be maintained in my confidential health and/or counseling record at The University of the South, and will not be re-disclosed without my separate written consent, unless such disclosure is permitted by law.

_____
Signature Date

For applicants whose separation from The University of the South involved reasons related to health

SEWANEE
THE UNIVERSITY OF THE SOUTH

CONSENT FOR UNIVERSITY WELLNESS CENTER TO RELEASE AND OBTAIN CONFIDENTIAL HEALTH CARE INFORMATION FOR REINSTATEMENT

Office of the Dean of Students (931) 598-1229

To the Student: Please complete this entire form and submit directly to Director, University Wellness Center, 735 University Ave., Sewanee, Tenn. 37383-1000. Phone (931) 598-1270. Fax (931) 598-1746.

Student's name _____
Last First Middle

Social Security Number _____ **Date of Birth** _____

Your Address _____
Street

_____
City State Zip Country

Day Phone _____ Other phone _____ E-mail Address _____

Health Care Provider /Facility Information:

Name _____

Business Address _____

_____
City State Zip Country

Phone _____ Fax _____ E-mail Address _____

Type of Records Authorized: ☐ Psychiatric/Psychological Evaluation and/or Treatment
☐ Drug/Alcohol Evaluation and/or Treatment

Specific information or records authorized (select one or more as appropriate):

☐ Attendance/Participation ☐ Assessments ☐ Progress Notes
☐ Disabilities/Accommodations ☐ Discharge/Treatment Summary ☐ Recommendations/Treatment Plans
☐ Verbal Consults ☐ All Clinical Records/Information (I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or HIV information, and I expressly consent to the release of the information.)

☐ Other: _____

As the person signing this consent, I understand that (1) I am giving my permission to the University Wellness Center to release information to and obtain information from the above-name provider/facility; (2) the purpose of disclosing this information and/or records is to assist in determining my readiness to return to The University of the South as a full-time student after a withdrawal for psychiatric, psychological, emotional, or substance abuse reasons; (3) the information released will be limited to that which is necessary to determine my readiness to return to The University of the South; (4) I am giving permission for consultation between health care providers, which may be required to clarify any information and/or records that are disclosed; (5) the University Wellness Center will make a recommendation regarding my application for reinstatement to the committee on reinstatement based on this confidential health care information, as well as any requirements for ongoing care on my return to The University of the South; (6) this information and/or records will be maintained in my confidential counseling record at The University of the South, and will not be re-disclosed without my separate written consent, unless such disclosure is permitted by law; (7) I may cancel this authorization at any time by submitting a written request to the University Wellness Center, except where a disclosure has already been made due to my prior authorization; (8) If I have authorized the disclosure of information to a recipient who is not subject to HIPAA, then the recipient may re-disclose the information and it may no longer be protected under privacy laws; (9) I freely give this consent and I do hereby release and hold harmless the University from any and all liability or damage, which may result from the disclosure of information herein authorized.

_____
Signature Date

This authorization expires: ☐ One Year from the date signed ☐ Other _____