CHARLOTTE
STUDENT ASSISTANCE AND SUPPORT SERVICES

349 Cone University Center
9201 University City Blvd
Charlotte, NC 28223
Phone: 704-687-0289 **Fax:** 704-687-1969
Website: withdrawal.charlotte.edu

Health Evaluation Form

For Students Requesting a Withdrawal due to Extenuating Circumstances

Student ID:_____ DOB:_____

Student Name: _____
(Last) (First) (MI)

Classification (circle one): Undergraduate Student Graduate Student Cell Number:_____

Please indicate the Academic Semester and Year for which you are requesting a withdrawal with extenuating circumstances.

Academic Semester (circle one): Fall Spring Summer Academic Year for Withdrawal: _____

Statement of Understanding

By signing where indicated below, I acknowledge that I have discussed and understand the ramifications that withdrawing will potentially have on my financial aid, on-campus housing, student health insurance, dining/meal plan, parking, withdrawal policy (16 credit hours), readmission policy, tuition refund status, visa status, counseling center services, experiential learning status, graduate student status, and/or other student status. I also understand that it is my responsibility to follow up with the appropriate student services office or department that requires additional information that cannot be answered by the Office of Student Assistance and Support Services (SASS), to better inform my decision to withdraw from the semester.

Student Signature:_____ Date: _____

The remainder of this form is to be completed by the treatment provider.

INSTRUCTIONS TO THE TREATMENT PROVIDER:

The student (patient/client) named above is a current student at the University of North Carolina at Charlotte requesting a withdrawal from classes for the current semester due to extenuating circumstances. The University of North Carolina at Charlotte requires documentation from a treating health care provider who can attest that the student is experiencing a condition that is significantly impacting the student's ability to meet the essential elements of their intended academic program of instruction. The University of North Carolina at Charlotte will weigh your opinion when considering the student's demonstrated need for withdrawal.

Provider/Clinician Name:	Today's Date:
Credentials of provider (Including License Number and Name of Practice):	
Student's diagnosis (Include ICD Code for Diagnosis):	Date of diagnosis:
	Date of most recent appointment:
	Total # of appointments this current term:

Please provide information regarding the student's symptoms, including comments on duration, intensity, and frequency.

☐ Yes ☐ No ☐ N/A	Is the student's condition significantly impacting the student's ability to function academically in their classes? If Yes, please describe:
☐ Yes ☐ No ☐ N/A	Is the student's condition significantly impacting the student's ability to function safely or autonomously without supervision in an academic environment? If Yes, please describe:

In your opinion, does the student's condition justify a withdrawal due to extenuating circumstances?

☐ No, the student's condition does not justify a withdrawal due to extenuating circumstances

☐ Yes, from all courses

☐ Yes, from a single class (including more than one but not all)

Please Explain:

What treatment have you recommended that the student receive in order to be ready to return to full enrollment at the University?

If additional space is required to fully respond to the questions above, please provide the following information on a separate document and attach to this form:

- ✓ Diagnosis and relevant medical history
- ✓ Medications and current treatment
- ✓ Treatment plan for the medical leave of absence
- ✓ Expected outcome of treatment during the medical leave of absence

ATTESTATION BY TREATMENT PROVIDER

By signing where indicated below, I am representing to the University of North Carolina at Charlotte that my response to each question listed above is true, complete, and accurate to the best of my knowledge and belief, that it constitutes my best professional judgment and opinion, and that the student/patient/client did not prepare or draft that response for my signature.

Signature:_____

Printed Name and Credentials:_____

Name of Company/Practice:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Please use additional pages or attach additional documentation if you wish to expand on your responses to questions above and/or to record any other comments or observations you may wish to make.

This form *must be* sent directly from the treatment provider. This form can be faxed confidentially to the Office of Student Assistance and Support Services by the treatment provider at 704-687-1969. Completed forms will not be accepted from students.