Licensed Provider Recommendation for Medical Withdrawal

Part I: Provider Information Please complete all information required.
Provider Name:_____ Practice Phone:_____
Practice Address: _____

Provider Credentials (please select):
MD/DO, Specialty: _____
Nurse Practitioner, Specialty: _____
Mental Health Professional, please specify: _____

NPI#:_____ License Number_____ Start Date of Issue: _____

Part II: Student Information

Patient's Full Name: _____
Patient's Date of Birth:_____ Patient's UNA L# (if known):_____

Part III: Clinical History Please complete all information required in detail. (Attach additional sheets if needed)

Patient's Diagnoses with ICD-10 and/or DSM codes

Describe how or why the condition is interfering or previously interfered with the patient's academic performance, safety or well-being at