Name of Student/Patient: ________________________________

(PLEASE PRINT)

To be Completed by Licensed Provider

1. Diagnosis: DSM IV (psychological) or Medical (include brief description):

____

____

____

2. Briefly describe treatment plan:

____

____

____

3. Please indicate the dates that reflect the scope of treatment for the medical or psychological illness/injury: ____

4. Based on your professional opinion, do you recommend that this student be granted a withdrawal from the course(s) indicated in Section B (please check 'yes' or 'no'.)
   ___yes ___no

____

Name of Licensed Provider (PLEASE PRINT)

____ ____________________________

Signature of Licensed Provider Date

____ ____________________________

License Number of Provider Phone Number of Provider

____

Address of Provider