UNC CHARLOTTE
Student Assistance and Support Services
118 King Building
9201 University City Blvd
Charlotte, NC 28223
Phone: 704.687.0289 **Fax:** 704.687.1969
Website: withdrawal.uncc.edu

Health Evaluation Form

For Students Petitioning for a Withdrawal with Extenuating Circumstances

Student ID: _____ DOB: _____

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

Undergraduate/Graduate student? _____ Cell Number: _____

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

Academic Semester of Withdrawal: _____ 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, housing, student health insurance, dinning/meals plan, withdrawal policy (16 credit hours), readmission policy, tuition refund status, visa status, counseling center services, experiential learning status and graduate student status. I also understand that it is my responsibility to follow up with the appropriate student services department that requires additional information that cannot be answered by the Dean of Students Office that applies to me to better inform my decision to withdraw from the semester.

Student Signature: _____ Date: _____

The remainder of this form 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 petitioning for a withdrawal from classes for the current semester. 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 his/her 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:	

Student's illness or condition (Include ICD Code for Diagnosis):	Date of diagnosis:
	Date of most recent appointment:
	Total # of appointments this current term:

Please provide information regarding student's symptoms (include comments on duration, intensity, and frequency) and how these symptoms impact the student's ability to function at the University.

☐ Yes ☐ No ☐ N/A	If the student's condition is significantly impacting the student's ability to function academically in her/his classes, what effect does the condition have on the student's ability to function academically? 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 it is not explained in detail within 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 can be faxed confidentially to Office of Student Assistance and Support Services by treatment provider at 704-687-1969.