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

Petition to Return Medical Evaluation Form

For Students Petitioning to Return

Student ID: ______________________________ DOB: ______________________________

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

Cell Number:______________________________

Please indicate the Academic Term and Academic Year for which you were withdrawn with extenuating circumstances.

Academic Semester of Withdrawal: ________________Academic Year of Withdrawal: ________________

Statement of Understanding

By signing where indicated below, I acknowledge that upon receipt of this medical documentation, the Withdrawal Committee will review and make a decision. I understand that the committee meets monthly and all decisions will be communicated through email. I also understand that it is my responsibility to follow up with the appropriate student services departments that requires additional information that cannot be answered by the Dean of Students Office that applies to me as I prepare to return to UNC Charlotte.

Student Signature: ________________________Date: ________________________

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

INSTRUCTIONS TO THE TREATMENT PROVIDER

The University of North Carolina at Charlotte requires documentation from a treating health care provider who can attest that the student who experienced a condition that significantly impacted their ability to meet the essential elements of his/her intended academic program of instruction, is now cleared to return. The University of North Carolina at Charlotte will weigh your opinion when considering the student's request to return.

Provider/Clinician Name:	Today's Date:
Credentials of provider (Including License Number and Name of Practice):	
Student's diagnosis:	Date of diagnosis:
	Date of most recent appointment:
	Total # of appointments post withdrawal date:

Please provide information regarding student's treatment that they have been involved in since leaving the university (include comments on duration, intensity, and frequency).	
☐ Yes ☐ No	Has the student followed all treatment recommendations? Please describe:

In your opinion, is the student in a place to return and continue their studies:

☐ Yes, at a full time schedule (at least 12 credits/4 or more classes)

☐ Yes, at a part time schedule (less than 12 credits/less than 4 classes)

☐ No, student is not well enough to return at this time

Please Explain:

What treatment have you recommended that the student continue to receive in order to ensure their well-being and stability?

A separate letter of support is needed to accompany this form, 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 moving forward
- ✓ Any concerns with the student returning to school