TEXAS SOUTHERN UNIVERSITY
REQUEST FOR MEDICAL WITHDRAWAL FORM

To be considered for a medical withdrawal, please accurately complete the entire form. Should you have questions, please contact the Dean of Students Office at 713-313-1038.

Section 1: Please complete the following information

Medical Withdrawal Requested For: Fall: _____ Spring: _____ Summer: _____

T-Number: _____ Today's Date: _____

Name: _____ Date of Birth: _____

Mailing Address: (We will send our decision to this address, so please ensure it is a valid address.)

_____

Street City State Zip

Phone: _____ Email: _____

Major: _____

□ Freshman □ Sophomore □ Junior □ Senior □ Graduate/Professional □ Law

Section 2: Please Check "Yes" or "No" for Questions A through D

A: Are you registered with the Office of Disability Services? □ Yes □ No

B: Do you reside in campus housing? □ Yes □ No

If yes, talk to the Office of Housing before completing this application. They will explain the financial impact of a semester withdrawal on your housing bill.

C: Are you receiving financial aid? □ Yes □ No

If yes, go to the Office of Financial Aid before completing this application. Request information on how this request could affect your financial aid. Your financial aid counselor must sign and date this application here.

Financial Aid Signature: _____ Date: _____

D: Have you applied for a medical withdrawal in the past? □ Yes □ No

If yes, please list date(s): _____

E: Veterans: If you receive ANY veteran education benefits, you must be seen by the Veteran Affairs office for information on how this request could impact your benefits.

Veteran Affairs Signature: _____ Date: _____

Section 3: Required Signatures

You are required to speak with your academic advisor to discuss the academic consequences of a medical withdrawal.

College/School: _____

Advisor/Chair/Dean Printed Name: _____ Extension: _____

Signature: _____ Date: _____

International students: Go to the International Students Office to receive information about how this request could affect your visa status.

International Advisor Signature: _____ Date: _____

Section 4: Description and Explanation

Describe your mental/physical health diagnosis or symptoms and explain why they are preventing you from attending class. Handwriting must be legible. You may attach additional pages if necessary.

_____

_____

_____

_____

_____

Section 5: Medical Documentation

You must submit along with the application either a signed letter from your provider or copies of your medical records. The documentation must include: 1) diagnosis or condition; 2) date of onset of the condition; 3) dates of treatment; and, 4) prognosis.

Attached is an Authorization to Release Medical/Mental Health Records, you may fill out the form and submit it to your health care provider.

Section 6: Student Statement and Signature

Please Initial:

- ___ I understand that completing this form does not guarantee I will receive a medical withdrawal.
- ___ I understand that it will take 5- 14 business days to review and process my application.
- ___ I understand that I will be notified of the decision by email or mail using the contact information provided in the application.
- ___ I understand that to be readmitted after a medical withdrawal I have to petition for readmission through the Dean of Students Office.

By signing, I affirm that I am requesting a medical withdrawal for the term listed on the application.

Printed Name: _____

Signature: _____ Date: _____

Texas Southern University

Authorization for the Use, Disclosure, and Receipt of Protected Health Information

I _____ request and authorize my Health Provider:

Name: _____ Specialty: _____
Address: _____ City/State/Zip: _____

To release my medical information to the University Student Health Services or University Counseling Center (as appropriate) for the purpose of a Medical/Mental Health Withdrawal review. *You must attach ALL Medical Documentation to this Form and send all relevant documentation to*:

Student Health Services
Student Health Center
Houston, TX 77004
Phone: (713) 313-7173 /Fax: (713) 313- 7817

OR

University Counseling Center
Student Health Center
Houston, TX 77004
Phone: (713) 313-7804 / Fax: (713) 313-7817

Records Authorized to be Obtained

Date Range and Specific Medical Records Requested: _____/ _____/ _____ to _____/ _____/ _____
(Note: The date range should be relevant to the Semester in question but may need to include relevant information just prior to the semester or immediately following).

Please Check all items you will be submitting to support your case:

_____ **ALL** Medical, Psychiatric, Counseling, or Psychological records including alcohol/drug abuse, addiction records, STD/HIV information within the date range noted above.

_____ General Medical Records (including all office visit notes, diagnostic tests, consultations, counseling and HIV information/test results).

_____ Mental Health Records only (Psychologist/Mental Health Counselor or Primary Care Clinician) *

_____ Psychiatry Clinic Records only* _____ Specific Evaluation or Consultation Report and date: _____

_____ Other _____

*__By law, Mental Health Care Professionals may substitute a summary letter in lieu of full records.__

Purpose of Disclosure:

Course Drop/Withdrawal: The Course Drop/Withdrawal Committee is made up of health care professionals who review the medical and/or mental health records; consultation with your appropriate Academic Dean or the Director of Withdrawal Services may be necessary but personal medical information is rarely shared. This authorizes the named person, agency, clinic or organization to release medical, mental health, psychiatric, social or psychological records including alcohol and drug abuse or addiction records, or STD information except as limited above.

I understand that the information in my records may include information relating to: Alcohol/Drug Abuse, STI/STDS, HIV/AIDS, Behavioral and/or Genetics.

I understand that a summary of the Mental Health records may be provided in lieu of complete Psychiatric records at the discretion of the Clinician.

I understand that once information is disclosed, the information is subject to redisclosure and may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this authorization at any time except in the case that action has already been taken regarding the request for authorization. **I understand** that if I revoke this authorization I must do so in writing and present my written revocation to the University Student Health Services or the University Counseling Center. I understand that the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire in six (6) months from the date signed below**.

Expiration Date: _____ **(If left blank, authorization will expire six (6) months)**

Name: _____ Birth date: _____/ _____/ _____ Phone: (_____) _____-_____

Address: _____

This release will be valid for _____from the date of my signature.

Signature of Student or *Legal Representative _____ Date: _____

Relationship: _____Date: _____

*** Note: Please attach a copy of the Power of Attorney**