

Readiness for Return from Medical Withdrawal

WELLNESS CENTER

220 Pawtucket Street, University Crossing, Suite 300

Lowell, MA 01854

Phone: 978-934-6800 fax: 978-934-3080

Email: Wellness\_Center@uml.edu

A student wishing to return to academic participation following a medical withdrawal must provide appropriate medical documentation from a licensed medical or mental health provider who is knowledgeable of the student’s health history and has treated the student for the condition necessitating the medical withdrawal. This documentation must indicate that it is appropriate and safe for the student to resume academic coursework at the beginning of a specified semester/term. A Readiness for Return from Medical Withdrawal form must be competed in full and submitted to the Wellness Center at the address above.

# STUDENT INFORMATION

Last Name First Name MI

Date of Birth  Student ID#

Term/Year to Return Term/Year of Medical Withdrawal

# PROVIDER INFORMATION

Provider Name Phone

Address Fax

Fax

Credentials/License Number

# CLINICAL HISTORY

Please complete all information required in detail. Additional information may be provided on office letterhead.

Student’s diagnos(es)

Diagnostic code(s) (ICD 10, DSM 5) Dates of care

Date of resolution to a level which does not interfere with the student’s academic performance.

Please describe how the student’s condition(s) has/have resolved or stabilized so as to not interfere with the student’s academic performance.

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# STUDENT INFORMATION

Last Name First Name Date of Birth

Please describe the plan of care developed with the student including medication, treatment/therapy, and follow-up, if needed, to maintain resolution or stability.

# Please confirm that the student is able to:

comments

Attend class ☐

Complete assignments ☐

Prepare/study for exams ☐

Complete labs, practicums, etc. ☐ Work collaboratively with peers ☐ Navigate a decentralized campus ☐

# Readiness for Return from Medical Withdrawal

In my professional judgement, my patient / client is

(name of student)

able to return to full academic and co-curricular participation at the University of Massachusetts Lowell as of

 . This student has given me permission to share the above information with the University of

(date)

Massachusetts Lowell and to discuss their medical information with the Director of Health services or the Director of

Counseling Services at the Wellness Center, if necessary.

Provider name

Date

Provider Signature / Credentials

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