Confidential

 **REQUEST FOR MEDICAL WITHDRAWAL**

WELLNESS CENTER phone: 978-934-6800

220 PAWTUCKET STREET, UNIVERSITY CROSSING, SUITE 300 fax: 978-934-3080

LOWELL, MA 01854 email: Wellness\_Center@uml.edu

To ensure confidentiality and privacy the **student** must complete and sign the Release of Medical Information section before submission of the document to their health care provider. All information will be kept strictly confidential and will be used only for the purpose of evaluating the student’s request for withdrawal from school and readiness to return to their academic work. The University reserves the right to impose conditions on return following a medical withdrawal, which will include the submission of additional documentation from the student’s health care provider and the student’s consent to discuss the student’s condition with university clinicians. Please note that there are no adjustments to tuition or fees based upon an approved request for medical withdrawal.

**In rare and exceptional cases, such as inpatient hospitalization or loss of consciousness, submissions may be considered after the final day of classes for the current semester.** To request this exception, students must provide a detailed explanation of the extenuating circumstances as part of their application.

This information will not become part of the student’s academic record or health record but will be retained in a separate administrative file.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the entire UMass Lowell Medical Withdrawal Procedure document and have had any questions answered.

The Medical Withdrawal Procedure can be found here: <https://www.uml.edu/student-services/health/medical-withdrawal-procedure.aspx>

Date

Student Signature

**RELEASE OF MEDICAL INFORMATION**

Last Name First Name MI Student ID#

Address

Date of Birth Phone

Semester and Year of Medical Withdrawal

Year of Study (Fr, So, Jr, Sr, Grad) Major

Date of last class attendance International Student? Yes No

I hereby authorize the release of information to the Wellness Center designee(s) at the University of Massachusetts Lowell for the purpose of determining my eligibility for an academic withdrawal due to medical circumstances. This information may include psychiatric care and/or treatment for alcohol and/or substance abuse.

For Administrative use:

* Date Received
* Approved
* Denied
* Pending

Date

Student Signature

Page 1 of 2

Revised 7/2025

**Student Information**

To be completed by medical provider.

Last Name First Name Date of Birth

**VERIFICATION FOR MEDICAL WITHDRAWAL** (Please complete all sections. Incomplete forms will be returned for further information.)

Diagnose(s)

Diagnostic code(s) (ICD 10 or DSM 5)

Date of Diagnosis Date of Hospitalization Date of Surgery

Current Medication(s)

Currently under treatment? Yes No

Dates of service: Initial visit Last visit Next scheduled visit

Please indicate the extent to which this student's condition interferes with their ability to function in the academic environment (attending classes, completing assignments/labs/practicums, take exams, safely navigate the environment):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that, in my professional opinion, the above-named student is unable to attend UMass Lowell for the current semester due to the medical conditions described above.

Provider Signature / Credentials:

Thank you for your assistance in completing this document. Please provide your contact information. We may need to follow up for additional details or to verify any of the documentation.

Provider's Name License #

Address Phone

City State Zip Code Fax

Date

Please return form to: Wellness Center phone: 978-934-6800

220 Pawtucket Street, Suite 300 fax: 978-934-3080

Lowell, MA 01854 email: Wellness\_Center@uml.edu

Page 2 of 2