UNI University of Northern Iowa

Return To:
Office of the Provost
University of Northern Iowa
Seerley 20
Cedar Falls, IA 50614-0707
PHONE: (319) 273-2518; FAX: (319) 273-3153
Attention: Cheryl Nedrow

STUDENT REQUEST MEDICAL DOCUMENTATION FORM

For Students Petitioning for Exceptions to University Policy

This section to be completed by the student

Student (Patient/Client) Name: _____

University Student ID: _____ DOB: _____

Phone:_____

University Student Request For:

- □ Late Semester Withdrawal for All Classes Due to Medical Condition Semester: _____
- □ Extenuating Circumstances Tuition and Fees Refund Semester: _____
- □ Extension of Recency Semester: _____
- □ Other: _____ Semester: _____

Statement of Release and Specific Authorization of Information Protected by State or Federal Law:

I authorize the release of medical information from the medical provider identified below to the University of Northern Iowa for use in decision consideration for the purpose(s) listed above. I understand that the information included in this form will be considered when determining my eligibility for exceptions to University policy. I understand that UNI may consult with campus professionals, including but not limited to personnel in the Student Health Clinic, Counseling Center, Dean of Students, or Student Accessibility Services when considering information contained in this form. A photocopy or exact reproduction of the signed consent shall have the same force and effect as the original. I understand I may review the information provided upon request.

- *I understand that I may revoke this authorization at any time, except to the extent that the action has already been taken, by giving written notice to the Office of the Provost. This authorization will expire six (6) months from the date of my signature, unless revoked earlier.*
- *I understand that any disclosure of information carries with it potential for re-disclosure. Once information is disclosed, it may no longer be protected by federal/state law, or the same federal/state law, and may be subject to re-disclosure.*
- *The information has been disclosed from records protected by federal and state confidentiality rules (e.g., 42 CFR Part 2) which prohibit any further disclosure of this information, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. The information is protected by Iowa law (e.g., Iowa Code Chapter 228) and/or federal law (e.g., 42 CFR Part 2), and the authorization is intended to comply with HIPAA and Iowa law.*
- *I acknowledge information to be released may include material applicable to substance abuse, mental health and/or AIDS-related information; and I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable spaces:]*
  - _____ *Substance Abuse (Drug or Alcohol) Information*
  - _____ *Mental Health Information*
  - _____ *AIDS-related Information, Diagnosis, and test results*

Student Signature: _____ Date: _____

This section to be completed by the medical treatment provider

INSTRUCTIONS FOR THE MEDICAL TREATMENT PROVIDER

The student (patient/client) identified above is a student at the University of Northern Iowa who is petitioning for withdrawal from one or more classes after the official withdrawal deadline (current or former semester) and/or an exception to other University policy as noted above. The University of Northern Iowa requires documentation from a licensed 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 and/or prevented the student from withdrawing from classes by the deadline for withdrawal. The university will weigh your opinion and information when considering the student's demonstrated need for exceptions to University policy. Students petition to withdraw from a full semester of classes unless a medical condition is documented with a unique differential impact on an identified class(es) that differs in essential demands than other courses in the semester from which the students is not petitioning for withdrawal.

Medical provider/Clinician name:	Credential of provider:
Student's diagnosed illness or condition:	Date of diagnosis:
Student's medical condition/illness (include DSM-V or other relevant diagnosis if applicable)	Most recent appointment:

	Total # of appointments: \# of missed appointments:

Please provide specific information regarding the student's symptoms (include comments on duration, intensity, and frequency) and how these symptoms are impacting the student's ability to successfully function at the University of Northern Iowa.

□ Yes □ No □ N/A	Did the student's condition significantly impact the student's ability to function academically across (all) classes throughout the semester or in the timeframe indicated? Please describe.
□ Yes □ No □ N/A	Did the student's condition impact the student from being able to withdraw from the class by the established deadline in the semester through regular university processes?
□ Yes □ No □ N/A	***For graduate students only: Did the student's condition impact the ability to complete the degree program within the time limits, i.e. 7 years for masters or 10 years for doctoral degrees?

In your professional opinion, does the student's condition justify consideration for a late course withdrawal and/or other exception to University policy as noted above?

□ No, the student's condition does not justify late course withdrawal
□ Yes from all classes
□ No opinion
□ Other: _____

Comments:

What treatment have you recommended, if any, that the student receive in order to be ready to return to successful enrollment at the University of Northern Iowa?

Based on the student's current condition, do you expect this student to reasonably be ready to return to enrollment at the University of Northern Iowa? And if so, do you have an approximate date for the student's ability to return to the University?

Please use additional pages or attach additional documentation if you wish to expand on your responses to the questions above and/or to record any other comments or observations you may wish to make regarding the student's need for exceptions to University policy.

ATTESTATION BY COMMUNITY/MEDICAL PROVIDER

By signing where indicated below, I am representing to the University of Northern Iowa that my response to each question and request for information is 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 the response for my signature.

Legal Signature: _____ Date: _____

Printed Name and Professional Credentials: _____

Address: _____

Phone: _____ FAX: _____