HEALTH & COUNSELING SERVICES
EASTERN ILLINOIS UNIVERSITY™

Provider Supporting Documentation

Medical/Psychological Withdrawal

Medical/psychological withdrawal: The student withdraws from all courses for the applicable semester rather than completing the remaining coursework under Incompletes.

Providers may complete this form OR submit a signed letter on professional letterhead addressing the same questions. Approximate dates are acceptable if identified. Include only clinically relevant information.

Student and treatment information

Student name: _____ Date of birth: _____

Provider name / credentials: _____

Treatment began: _____ Most recent visit: _____ Frequency: _____

Treatment relationship: ☐ Ongoing care ☐ Limited visits ☐ One-time assessment

Diagnosis/condition and clinical timeline

Relevant diagnosis/condition or symptoms (or significant clinical circumstances if no diagnosis):

_____

_____

_____

_____

Approximate onset/significant incident: _____ Date symptoms significantly worsened: _____

Date academic functioning became substantially impaired (if known): _____

Relevant clinical events/dates (e.g., hospitalization, crisis care, procedure), if applicable:

_____

Impact on academic and daily functioning

Areas affected (check all that apply):

☐ Attendance/participation ☐ Assignments/exams ☐ Concentration/memory

☐ Academic performance ☐ Daily functioning/independent living

☐ Other: _____

Briefly describe how the condition affected academic participation or coursework, including when the impairment became substantial:

_____

_____

If applicable, describe effects on independent living or essential daily activities (e.g., self-care, housing, managing basic needs):

_____

_____

Clinical recommendation and treatment plan

Do you clinically support withdrawal from all courses for the applicable semester? ☐ Yes ☐ No ☐ Unable to determine

Why is withdrawal from all courses clinically indicated, rather than continuing or completing coursework?

_____

_____

Recommended treatment/aftercare during leave or withdrawal:

_____

_____

For prior-semester requests only: Clinical circumstances contributing to delayed request (if known):

_____

_____

Provider verification

This information reflects my professional assessment and available clinical information. Student-reported history should be distinguished from directly observed or documented findings when relevant.

Provider signature: _____ Date: _____

Practice/organization: _____ _____ License no. (optional): _____

Phone/email: _____

Provider recommendations inform review but do not guarantee approval. Clarification may be requested with appropriate authorization.

Form submission

Submit this form or provider letter to Georgia Ryan, Health & Counseling Services:

Email: garyan@eiu.edu | Fax: 217-581-5980

Mail/in person: Human Services Building, Room 1200, Eastern Illinois University, Charleston, IL 61920

Questions: Health & Counseling Services 217-581-3413