OFFICE OF THE VICE PRESIDENT FOR STUDENT AFFAIRS
JACKSONVILLE STATE UNIVERSITY

Licensed Provider Recommendation for Hardship Withdrawal

Provider: ____ Phone: ____________________

Address: ____ City: _______________ State: _______

Provider Credentials. **Mark all that apply:** ☐ **MD** ☐ **DO** ☐ **DNP**

☐ **Mental Health Professional** Please specify: ______________________________________

NPI #: ________________________ License Number: ___________________State of Issue: ________

Patient's Full Name: ____

Patient's Date of Birth: ____

Patient's Diagnoses with ICD-10 and/or DSM Codes: ___________________________________

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How has the condition interfered with the patient's academic performance, safety, or wellbeing at Jacksonville State University during the term for which the patient requested a medical withdrawal?

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Please provide any additional information relevant to your recommendation for medical withdrawal for the patient on office letterhead and attach.

With my signature below, I provide my recommendation for medical withdrawal from the _______term or semester, 20____ at Jacksonville State University. The patient has given me permission to share the foregoing information with Jacksonville State University officials.

Signature: ____ Date: _________________

Stamp: ____

III:13

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