



Medical Withdrawal Return Documentation

The LTC's Office of Learning Resources (OLR) works with any student seeking to medically withdrawal from the university. This form can be shared by the student with the service provider in order to document the need for a medical withdrawal.

Part A: TO BE COMPLETED BY STUDENT

Family/Last Name: _____

First Name: _____

Student ID: _____

Phone: _____

Date of Birth: _____

Semester of Request: _____

Current Address: _____

Street name & Number

City State Zip

(Where you live while attending University of Dayton)

I do hereby authorize the release of records and/or information with no limitation, which may include treatment for psychiatric illness, alcohol or drug abuse and/or HIV test results or AIDS/ARC diagnosis. I understand this authorization may be revoked by me at anytime and in any event, automatically expires 60 days from this date.

Signature of Student/Date

Return information

This 2-page form should be returned to the Office of Learning Resources via fax (937-229-3270), email: disabilityservices@udayton.edu, hand deliver (Room 023 Roesch Library) or mail (University of Dayton, Attention Office of Learning Resources, 300 College Park, Dayton Ohio 45469-1302)



Part B: To be completed by LICENSED MEDICAL/PSYCHOLOGICAL PROFESSIONAL

Release date for return to academic environment: _____

General description of the illness/condition and treatment

What has changed in the student's circumstances that make her/him ready to return?

What support the student anticipates needing at the university, if any?

Provider Signature: _____

Date: _____

Print name: _____

Specialty: _____