

# Licensed Provider Recommendation for Medical Withdrawal

**Part I: Provider Information** Please complete all information required.

Provider Name: \_\_\_\_\_ Practice Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Provider Credentials (please select):

MD/DO, Specialty: \_\_\_\_\_

Nurse Practitioner, Specialty: \_\_\_\_\_

Mental Health Professional, please specify: \_\_\_\_\_

NPI#: \_\_\_\_\_ License Number \_\_\_\_\_ Start Date of Issue: \_\_\_\_\_

## **Part II: Student Information**

Patient's Full Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Patient's UNA L# (if known): \_\_\_\_\_

**Part III: Clinical History** Please complete all information required in detail. (Attach additional sheets if needed)

Patient's Diagnoses with ICD-10 and/or DSM codes

Describe how or why the condition is interfering or previously interfered with the patient's academic performance, safety or well-being at