TREATING HEALTHCARE PROFESSIONAL
REPORT FORM
Request for
Course Withdrawal for Medical Reasons

Section 1: To be completed by the student

Student Name: _____Date of Birth: _____ Berg ID: _____

I am requesting a:
☐ Withdrawal for Medical Reason from the following course(s) for current semester

Semester	Department	Course and section number	Course Name	Professor	Units

I understand and consent to the following: The information below will be reviewed by the Office of the Vice President of Student Affairs/ Dean of Students. I understand that the VP of Student Affairs/ Dean of Students may share this information with other Muhlenberg College officials, as necessary, for the purpose of review of the Course Withdrawal request.

Student Signature: _____ Date:_____

Section 2: To be completed by licensed treatment provider.

This is to be completed by the student's treating physician, licensed mental health provider, or other licensed healthcare provider. The provider must be an impartial diagnostician who does not have an immediate familial relationship with the student.

Providers: The above-named student has requested a Course Load Reuction for Medical Reasons from Muhlenberg College, claiming to have had a condition preventing him/her/they from meeting the expectations of a student during the above indicated term. The student reports that you have evaluated or treated him/her/they for that condition during that time period. Please address every question listed below by either completing the form or by writing a summary on letterhead and returning it to the VP of Student Affairs/ Dean of Students at the address noted below.

- Name of Student/ Patient:_____ Date of Birth: _____
- Provider's Name: _____ Provider's Title/ Degree: _____

  Provider's Area of Medical/ Mental Health Specialization: _____

  Office Address: _____

  Office Telephone: _____ Fax:_____
- Your assessment and treatment of the student

1. ☐ Medical in nature ☐Psychological in nature ☐ Other_____

2. How long have you known this student:_____

3. Approximate date the symptoms of current episode/exacerbation first began:_____

4. Approximate date(s) of your treatment/ assessment _____/_____/_____ to _____/_____/_____

5. Diagnoses:_____

6. Symptoms – Please explicitly state the functional impairments that inhibit the student from attending class and/or completing coursework:
   _____

   _____

   _____

7. Treatment Recommendations:
   _____

   _____

- Any additional information the healthcare provider thinks it will be helpful for the College to know.
  _____

  _____

- **Your Recommendation:** Do you believe that the student, due to the condition(s) described above, was unable to meet the expectations of a student for the specified course? ☐ Yes ☐No
  Please include additional comments as necessary.
  _____
  _____
  _____

Signature of provider: _____ Date:_____

Signed letters or forms can be mailed or faxed to:

Office of the Vice President of Student Affairs/ Dean of Students
Muhlenberg College, 2400 Chew Street, Allentown, PA 18104
Telephone: 484-664-3182; Fax 484-664-3930