



COURSE LOAD REDUCTION FOR MEDICAL REASONS Student Information – Please Read Carefully

A course load reduction is the process of reducing your class schedule for medical reasons in a designated semester and year. As a student at Northern Illinois University, you may be eligible for a course load reduction if you experience a serious medical condition that affects your class attendance and/or participation during the semester/year designated. A request for a course load reduction requires Health Services to review medical documentation before making a recommendation (not an approval) to the college, who will make the final decision for approval and academic status.

1. You must contact the Advising Dean of your Academic College (see below) to make them aware you are requesting a course load reduction from the university for medical reasons.

Business-Barsema Hall
College of Law (undergrad)-Swen Parson
Education-Graham Hall
Engineering-Engineering Building
Health & Human Sciences-McMurry Hall

Liberal Arts & Science-Zulauf Hall
Visual & Performing Arts-Music Building
Undecided, Academic Advising Center-Adams Hall
Graduate School-Adams Hall 210

2. A complete and witnessed *Student Application and Authorization for Course Load Reduction* (page 2) must be submitted to Health Services Administration Office, Room 422.
3. It is your responsibility to contact your healthcare provider/s asking them to submit the *Licensed Provider Documentation Form for a Course Load Reduction* (page 3) to Health Services documenting the serious medical condition that affected your class attendance and/or participation during the designated semester/year. The original, signed documents must be received by Health Services before a medical review begins. Please do NOT fax forms to the Health Services.
4. The Health Services administrative physician will review all medical documentation submitted by a medical provider/s in support of your request of a course load reduction for medical reasons. Medical review will be completed in approximately 5 to 7 working days after medical information is received by Health Services. Your academic college will be notified of the *Recommendation*; you (the student) will receive a copy of the memo as well. Your academic college determines the final outcome of your medical request and academic status.
5. If you were treated for your medical condition by Health Services medical staff during the designated semester, you may authorize the practitioner(s) to submit medical documentation in support of your application for a course load reduction. A Health Services *Authorization for Release of Confidential Information for Administrative Purpose* (page 4) must be completed.
6. If the medical information provided is not sufficient, Health Services will notify you by letter of this determination. You may submit additional, new medical information for administrative physician review

Please contact the NIU Health Services Administration Office if you have any questions: 815-753-1316 or 815-753-9747, Monday – Friday 8 AM – 4:30 PM.



PROVIDER DOCUMENTATION FORM – COURSE LOAD REDUCTION

Student’s Full Name _____ Z-ID# _____

Semester and Year _____ DOB _____

Please type or print the requested information in the space provided below and return this form with original signature to address above. Do NOT fax.

Air-conditioning in residence halls is only available until mid-September on a limited basis.

<p>1. Diagnosis and code of the severe medical condition that significantly impaired or affected student’s class attendance or participation during the above semester.</p>	
<p>2. For the above condition, indicate the</p> <ul style="list-style-type: none"> ▪ date(s) of evaluation and/or treatment and follow-up visits during the above semester; ▪ location of evaluation and/or treatment (e.g., office, hospital OP, hospital IP, etc.); and ▪ Nature or purpose of each evaluation and/or treatment provided. 	
<p>3. Provide any specific medical findings, restrictions and/or other <u>objective</u> data that document how the above student’s class attendance or participation was significantly impaired or affected during the above semester and year.</p>	

Signature of Attending Licensed Healthcare Provider and Title

Date

Printed Name, Business Address, Telephone Number



NORTHERN ILLINOIS UNIVERSITY

HEALTH SERVICES
Administration Office, Room 422
Northern Illinois University
DeKalb, IL 60115
(815) 753-1316

Authorization for Release of Confidential Health Information for Administrative Purposes

Name: (Last) _____ (First) _____

Z-ID# ____/____/____ Date of Birth ____/____/____ Phone# (____) _____

Address _____ City _____ State _____ Zip _____

I, the above named patient, authorize NIU Health Services to release my confidential health information to the Health Services Administrative Physician for the purpose of administrative review of my request for a Medical Withdrawal, Course Load Reduction or Special Housing/Dining Arrangement at Northern Illinois University.

Please list the names of the NIU Health Services Practitioners and staff authorized by this release:

Please indicate information and dates to be released:

- Immunizations _____ Lab results _____
Office visit notes _____ X-ray results or film _____
Other _____

Diagnoses of Mental Health, Alcohol and Substance Abuse and Infectious Disease (AIDS/HIV) are NOT included in a general release. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require diagnoses of Mental Health, Alcohol and Substance Abuse and Infectious Disease information to be specifically indicated. Please indicate information and specify dates to be released and initial.
Mental Health _____ Alcohol and Substance Abuse _____ Infectious Disease _____

I understand that I have the right to inspect and/or obtain a copy, for an appropriate fee, of the information prior to disclosure. I may revoke this authorization at any time, except to the extent that action has already been taken, by submitting a written revocation to Northern Illinois University, Health Services. If I refuse to sign this authorization, my medical record/information will not be released. This authorization will be considered valid for a 90-day period (expiration date / /) following the date of signature unless otherwise specified here _____. I absolve the individual or agency identified above and the Board of Trustees of Northern Illinois University together with its officers and employees from any legal liability which may arise from the disclosure of this information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Print Name: _____

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without patient authorization for such disclosure.

Processed by _____ Date Processed _____