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

MEDICAL WITHDRAWAL
Student Information – Please Read Carefully

A medical withdrawal is a complete withdrawal from all university classes in a designated semester and year. As a student at Northern Illinois University, you may be eligible for a medical withdrawal if you experience a serious medical condition that affects your class attendance and/or participation during the semester/year designated. A request for a medical withdrawal requires Health Services to review medical documentation before making a recommendation (not an approval) to the college, who will make the final decision regarding approval and academic status.

1. You must contact the Advising Dean of your Academic College (see below) by letter.

   Business-Barsema Hall
   College of Law (undergrad)-Swen Parson
   Education-Graham Hall
   Engineering-Engineering Building
   Health & Human Sciences-McMurry Hall
   Liberal Arts & Science-Zulauf H
   Visual & Performing Arts-Music Building
   Undecided, Academic Advising Center-Adams Hall
   Graduate School-Adams Hall

2. If you are in a university residence hall, please notify the NIU Housing & Dining office for arrangements to move out.

3. A completed and witnessed *Student Application and Authorization for Medical Withdrawal* (page 2) must be submitted to Health Services Administration Office, Room 422.

4. It is your responsibility to contact your healthcare provider/s asking them to submit the *Licensed Provider Documentation Form for a Medical Withdrawal* (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 any information to Health Services.

5. The Health Services administrative physician will review all medical documentation submitted by a medical provider/s in support of your request of a withdrawal from the university 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.

6. If you were treated for your medical condition by Health Services medical staff during the designated semester and year, you may authorize the practitioner(s) to submit medical documentation in support of your application for a medical withdrawal. A Health Services *Authorization for Release of Confidential Information for Administrative Purpose* (page 4) must be completed.

7. If the medical information provided is not sufficient, Health Services will notify you by letter of this determination. You may submit additional medical information for the administrative physician review.

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

NORTHERN ILLINOIS UNIVERSITY

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STUDENT APPLICATION AND AUTHORIZATION
MEDICAL WITHDRAWAL FROM UNIVERSITY

I am seeking a medical withdrawal from the University for the semester and year identified below.

Name ____ Z-ID#_______________________

Address ____

City ____ State __________ Zip Code ___________

Current daytime telephone number ___________________________ Date of Birth ___________

Semester (circle one) Fall Spring Summer Interim Year ________________

Please check one box: ☐ Undergraduate Student ☐ Graduate Student

I HEREBY REQUEST AND AUTHORIZE the administrative physician or physician designee of Health Services, Northern Illinois University, DeKalb, IL 60115:

1. To verify the presence of an acute and/or prolonged, severe medical condition during the above semester to be forwarded to the Advising Dean, College of: ______________________________

2. *(Optional)* The person/s listed below has my permission to discuss the status of my request for a university medical withdrawal (e.g., parent, spouse, etc.):

____

(Name of person and relationship to applicant)

I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure and that my refusal to authorize disclosure of this information will result in the following consequence: Unexcused academic absence.

I may revoke this authorization at any time by written notification to Health Services. However, I understand revocation cannot be retroactive. I absolve and agree to hold harmless the individual or agency identified above, and the NIU Board of Trustees, together with its officers and employees, from any legal liability, claims or damages which may arise from disclosure of this information. Unless revoked, this consent is valid until the request is completely processed.

____ ____

Signature of applicant Date Signature of Witness Date

____

Print Name

Please return completed form to the address above.

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PROVIDER DOCUMENTATION FORM – MEDICAL WITHDRAWAL

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 the address above. Do NOT fax.

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

1. Diagnosis and code of the severe medical condition that significantly impaired or obstructed student's class attendance or participation during the above semester.	
2. For the above condition, indicate the ▪ **date(s) of evaluation and/or treatment 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.**	
3. Provide the specific medical findings, restrictions and/or other objective data that document how student's class attendance or participation was significantly impaired or obstructed during the above semester.	

____
Signature of Attending Licensed Healthcare Provider and Title Date

____
Printed Name, Business Address, Telephone Number

COMPLETE THIS FORM ONLY IF SEEN BY AN NIU HEALTH SERVICES PRACTITIONER

NORTHERN ILLINOIS UNIVERSITY

HEALTH SERVICES
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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 ____________________________________
- ☐ Office visit notes__________________________________
- ☐ Other ____
- ☐ Lab results ________________________
- ☐ X-ray results or film _______________

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 __________________