If this is a medical leave, name of healthcare professional you have seen who recommends or supports your taking a Medical Withdrawal if applicable.
Name of healthcare professional: ____
Date of Recommendation: ____

Healthcare professional documentation, in the Provider Recommendation form, must include:

1. Your medical condition with diagnosis.
2. The reason a Medical Withdrawal is recommended.
3. Treatment plan – including medications and specific treatments or type(s) of therapy if prescribed.

Please initial each of the statements below, indicating your understanding and agreement:

________ I am responsible for understanding and addressing all academic, financial, and health insurance-related ramifications of taking a Medical Withdrawal, and that I am required to contact my Academic Advisor to discuss my academic plan upon re-entry from medical withdrawal.
________ I confirm that all the information provided as part of this request is true and accurate.
________ I understand that approval of a medical withdrawal is subject to Morehouse School of Medicine's review, and dependent on my complete and timely submission of the request application and related materials, including the provider form. I understand that if the provider form is not submitted, Morehouse School of Medicine's will make a decision only on the information Morehouse School of Medicine's possesses.
________ I understand that the deadline for requesting a medical withdrawal is the last day of classes and that requests and materials submitted after that date, or a departure unaccompanied by any request, will be treated as a voluntary withdrawal.
________ I understand that I must be in contact with Morehouse School of Medicine's, and submit required requests and documentation, by the return deadline, in order to be considered for reinstatement and return. I further understand that I must be in contact with Morehouse School of Medicine's by the return deadline if I require an extension of my time away on medical withdrawal, and that such a request will require provider substantiation and Morehouse School of Medicine's approval.
________ I understand that Morehouse School of Medicine's may establish conditions that must be satisfied prior to my return, depending on the individual circumstance of my case. I also understand, depending on the individual circumstances of my case, that I may be required to follow a treatment plan recommended by an outside and/or Morehouse School of Medicine's health/mental health professional as a condition of returning to the campus community.

Student's Signature: ____________________________________ Date: _________________________

Address during leave: ____
Phone number during leave: ____

Please return this form to:

Office of Inclusive Learning and Accessibility Services
Attention: DeQuan M. Smith, EdD
Email: oilas@msm.edu

Medical Withdrawal Questionnaire

We encourage you to write a brief statement explaining why you are seeking a medical withdrawal to help us understand your reasons for leaving, and to provide other information you would like us to know.

1. **Reason for withdrawal:** Please provide a brief description of the reason for your request; include how your health issues have had an impact on you (i.e. on your academic standing, class participation, class attendance, social engagement).

2. **Goals for your time away:** How will your time away improve your health and contribute to your successful return to Morehouse School of Medicine's?

3. **Activities during your time away:** Indicate any activities you plan to participate in while away (i.e. job, internships, classes).

Office of Inclusive Learning and Accessibility Services
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