Current Semester Medical Withdrawal/Course Load Reduction Application

The University of Texas at Austin

University Health Services • Counseling & Mental Health Center • Disability and Access

STEP 1 Please complete the following information.

Name: _____ **Today's Date:** _____

UT EID: _____ **Date of Birth:** _____

Address: (We will mail our decision to you at this location.)

_____

Street **Apt./Room** **City** **State** **Zip Code**

Phone: ( ) _____ **Email:** _____@_____

College/School: _____

❑ **Freshman** ❑ **Sophomore** ❑ **Junior** ❑ **Senior** ❑ **Graduate Business** ❑ **Law**

STEP 2 Check the type of action you are requesting.

❑ **Current semester medical withdrawal**

❑ **Course load reduction** **List course(s)**: _____ _____ _____ _____

NOTE: The illness or injury must directly impact the class(es) you wish to drop.

STEP 3 Please check "Yes" or "No" for Questions A through D.

A. **Are you registered with Disability and Access?** ❑ Yes ❑ No

B. ***CURRENT SEMESTER WITHDRAWAL ONLY*: Do you reside in campus housing?** ❑ Yes ❑ No
If yes, check with Housing and Dining at (512) 471-3136 or www.utexas.edu/student/housing *before* completing this application. They will explain the financial impact of semester withdrawal on your housing bill.

C. **Are you receiving financial aid?** ❑ Yes ❑ No
If yes, go to the Texas One Stop, MAI 1 (Ground floor of the UT Tower) for information about how this request could affect your financial aid. Your financial aid counselor must sign and date this application here.
One Stop Coordinator signature: _____ **Date:** _____

D. **Have you applied for a medical withdrawal or a medical course load reduction before?** ❑ Yes ❑ No
If yes, please list date(s) and type(s): _____

E. **VETERANS/DEPENDENTS: Are you a veteran/dependent using Veteran Education Benefits?** ❑ Yes ❑ No
If you are currently receiving or applying for ANY Veteran Education Benefits (G.I. Bill® and/or Hazlewood), you must meet with the Veteran Certification VA School Certifying Officials (SCOs), Texas One Stop MAI 1, for information about how this request will affect your benefits. An SCO must sign and date this application here: **SCO Signature:** _____ **Date:** _____

STEP 4 Get required signatures.

This section must be completed by your Dean's office advisor or, if applicable, your College of Natural Sciences nonacademic counselor in your Dean's office:

Dean's office Advisor/Counselor (PLEASE PRINT): _____

Signature of Advisor/Counselor:_____Date:_____

School/College: _____

My signature verifies I have advised this student about the academic consequences of this request.

My signature does not guarantee the Dean's approval of this request.

GRADUATE STUDENTS in McCombs and Texas Law:

- **MBA/MPA candidates:** Contact your advisor in the McCombs School of Business to obtain signature above
- **J.D./LL.M. candidates:** Contact your advisor in your Dean's office to obtain signature above
- **If you have a TA, AI, GRA, fellowship, etc., signature of supervisor:** _____

My signature verifies I have advised the student about the consequences of this request on the student's academics and/or appointment/award.

INTERNATIONAL STUDENTS: Contact International Student and Scholar Services (ISSS) for information about how this request could affect your visa status (located at 2400 Nueces Street, Ste. B). Your International Office advisor must sign and date this application here.

Advisor's Name (PLEASE PRINT): Advisor's Signature Date:

STEP 5 Description and Explanation

Describe your mental/physical health diagnosis or symptoms and explain why they are preventing you from attending and/or continuing in class. Handwriting must be legible. You may attach additional pages if necessary.

_____

_____

_____

_____

_____

_____

STEP 6 Medical Documentation

Course Load Reduction: Mental health course load reductions will require documentation meeting D&A documentation guidelines. Please visit https://disability.utexas.edu/documentation-guidelines/, or call (512) 471-6259, or ask for a verification form at the D&A front desk. You are responsible for ensuring the necessary documentation is provided, regardless of where you received care – CMHC, UHS, or an outside provider.

Medical Withdrawal: If you have received care for this condition at UHS or CMHC, we have access to your records and you do not need to provide copies.
Name(s) of provider(s) you saw at UHS and/or CMHC:_____

If you have received care outside of UHS or CMHC for this condition, you must submit – along with the application – either a signed letter from your provider or copies of your medical records. The documentation must include: 1) diagnosis or condition; 2) date of onset of the condition; 3) dates of treatment; and, 4) prognosis.
Name(s) of off-campus provider(s): _____

STEP 7 Effective Date

The effective date of this request is the date the application and ALL requested documents are received by our office. If there are extenuating circumstances that would change this date, please explain:

_____

Title IX

Disability and Access (D&A) staff are designated as confidential employees, meaning we are not required to disclose your personal information regarding incidences of sexual misconduct to the Title IX office. We are still required to make a report of incidences of sexual misconduct, which includes sex and gender discrimination, sexual harassment, sexual assault, dating and domestic violence, stalking, sexual exploitation, and any other forms of inappropriate sexual conduct. **PLEASE NOTE:** Others who may view this application may not hold confidential status and would be required to report as a responsible employee. For more information about our policies on sexual misconduct, please visit the Handbook of Operating Procedures (HOP) 3-3031. Information related to incidents of sexual misconduct that is disclosed in documentation may be reported to the Title IX Office. Disability/diagnostic information will be kept in accordance with D&A's Confidentiality Guidelines.

AUTHORIZATION TO RELEASE INFORMATION

I request and authorize The University of Texas at Austin University Health Services, Counseling & Mental Health Center, and/or Disability and Access to discuss with each other, appropriate deans, faculty and administrators the outcome of my request for a course load reduction or current semester medical withdrawal. I understand this information may be shared among UHS, CMHC and D&A staff for processing purposes. I further authorize that applicable UT departments be notified of approval or denial of this request. This authorization extends to the Office of Student Conduct and Academic Integrity, who will be notified of my application. By my signature, I affirm that all personal statements and documents submitted are true and correct and give consent to being contacted via email about the status of my application.

Student's Signature: _____ Date: _____

Please email, mail, deliver, or fax this form and all supporting medical documentation to:

- **Mailing address**:
  CLR/MW, Disability and Access
  100 West Dean Keeton Street STOP A4100 • Austin, TX 78712-1093
- **Office location**: Student Services Building • SSB 4.206
- **Fax**: (512) 475-7730
- **Email**: access@austin.utexas.edu

THE UNIVERSITY OF TEXAS AT AUSTIN

- COUNSELING AND MENTAL HEALTH CENTER
- UNIVERSITY HEALTH SERVICES
- DISABILITY AND ACCESS

100 West Dean Keeton Street • Austin, Texas 78712

AUTHORIZATION TO RELEASE INFORMATION

Please be advised that your health records constitute privileged information that is protected by the laws of the State of Texas and that they may contain information that is protected under Federal Confidentiality Regulations. These records cannot be disclosed without your written consent unless otherwise provided for in the federal regulations. Authorizing the release of information contained in your health records constitutes waiver of a privilege. You may revoke this consent through written notice, but it will not apply to action that has been taken prior to receipt of the revocation.

I, _____
(PLEASE PRINT) LAST NAME FIRST NAME MIDDLE INITIAL

Request and authorize:

PROVIDER NAME _____ **PHONE** _____

STREET ADDRESS _____ **FAX** _____

CITY _____ **STATE** _____ **ZIP**

To release to and discuss with:	The University of Texas at Austin	PHONE	FAX
	☐ Counseling and Mental Health Center	512-471-3515	512-232-7314
	☐ University Health Services	512-471-4955	512-471-0898
	☐ Disability and Access	512-471-6259	512-475-7730

the following information from the record of my care and treatment (please check *ALL* categories that apply):

- ☐ Counseling and/or psychiatric record
- ☐ Office visit notes
- ☐ Laboratory reports
- ☐ Life history questionnaire
- ☐ Client status/intake information
- ☐ Medical record
- ☐ Dates of appointments
- ☐ Operative reports
- ☐ Radiology reports
- ☐ Other, as specified below

Other: _____

The disclosure as authorized herein is made for the following purpose: *Discuss application for medical withdrawal or course load reduction*

Please note, the law prohibits further dissemination or use of these records for other purposes.

I specifically authorize the release of information pertaining to drug and alcohol abuse and/or HIV testing/test results if such is a part of the record. Release or transfer of the specified information to any person or entity not specified herein is prohibited by law.

_____
CLIENT SIGNATURE

On this, the_____day of_____, 20___, I have read or have had read to me, the terms and conditions of this agreement and fully understand same. I do freely, voluntarily, and without coercion agree to those terms and conditions contained herein.

_____
SIGNATURE OF WITNESS

_____
SIGNATURE OF CLIENT

_____
UT EID

_____
DATE OF BIRTH

_____
PHONE