**Current Semester Medical Withdrawal/Course Load Reduction Application**  
The University of Texas at Austin  
University Health Services • Counseling & Mental Health Center • Services for Students with Disabilities

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**STEP 1**  
Please complete the following information.

<table>
<thead>
<tr>
<th>Name: _________________________</th>
<th>Today’s Date: __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>UT EID: _________________________</td>
<td>Date of Birth: __________</td>
</tr>
<tr>
<td>Address: (We will mail our decision to you at this location.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

| 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 Services for Students with Disabilities?  ❑ Yes  ❑ No

B. **CURRENT SEMESTER WITHDRAWAL ONLY:**  Do you reside in campus housing?  ❑ Yes  ❑ No  
   If yes, check with Housing and Food Service 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 Office of Financial Aid (OFA), SSB 3.200 for information about how this request could affect your financial aid. Your financial aid counselor must sign and date this application here.

   SFS Counselor 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:** If you are receiving ANY veteran education benefits, you must be seen by Student Veterans Services (SVS), SSB 4.472 for information about how this request could affect your benefits. Your SVS advisor must sign and date this application here.

   SVS Advisor signature: ________________________ Date: ____________

**STEP 4**  
Get required signatures.

This section to 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:** Go to the International Office lobby at building INT for information about how this request could affect your visa status. Your International Office advisor must sign and date this application here.

Advisor’s Name (PLEASE PRINT): ________________________  
Advisor’s Signature ________________________ Date: ____________

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FORM – Medical Withdrawal 10/24/2017
STEP 5  Description and Explanation

Describe your mental/physical health diagnosis or symptoms and explain why they are preventing you from attending 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 SSD documentation guidelines. Please visit www.utexas.edu/diversity/ddce/ssd/doc.php, or call (512) 471-6259, or ask for a verification form at the SSD 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:

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

AUTHORIZATION TO RELEASE INFORMATION

I request and authorize The University of Texas at Austin University Health Services, Counseling & Mental Health Center, and/or Services for Students with Disabilities 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 SSD staff for processing purposes. I further authorize that applicable UT departments be notified of approval or denial of this request. This authorization extends to Student Judicial Services, 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 mail, deliver, or fax this form and all supporting medical documentation to:

- **Mailing address:**
  CLR/MW Application Coordinator, Services for Students with Disabilities
  100 West Dean Keeton St. STOP A4100
  Austin, TX 78712-1093
- **Office location:** Student Services Building • SSB 4.206
- **Fax:** (512) 475-7730
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:

<table>
<thead>
<tr>
<th>PROVIDER NAME</th>
<th>PHONE</th>
<th>FAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Texas at Austin</td>
<td>512-471-3515</td>
<td>512-232-7314</td>
</tr>
<tr>
<td>Counseling and Mental Health Center</td>
<td>512-471-4955</td>
<td>512-471-0898</td>
</tr>
<tr>
<td>University Health Services</td>
<td>512-471-6259</td>
<td>512-475-7730</td>
</tr>
</tbody>
</table>

To release to and discuss with:

☐ Counseling and Mental Health Center
☐ University Health Services
☐ Services for Students with Disabilities

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

☐ Counseling and/or psychiatric record
☐ Medical record
☐ Office visit notes
☐ Dates of appointments
☐ Laboratory reports
☐ Operative reports
☐ Life history questionnaire
☐ Radiology reports
☐ Client status/intake information
☐ 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 ______________________