Miami University Provider Report Form (PRF)

This Medical Withdrawal Provider Report form must be completed in full. Any blank spaces may lead to a delay in processing your request. Please type, or print clearly in ink.

Section 1: To be completed by the student:

Student Name: _____ Date of Birth: _____ Banner ID#: _____

Permanent Street Address: _____

Permanent City, State and Zip Code: _____

Phone: _____ Cell Phone: _____ Preferred email: _____

Term (e.g. Fall, Winter, Spring, Summer) for which you are requesting a Medical Withdrawal (MW): _____

Year for which you are requesting an MW: _____

I understand and consent to the following: The information below will be reviewed by the Office of the Dean of Students. I also understand that the Dean of Students may share this information with other Miami University officials, as necessary, for the purpose of review of the Medical Withdrawal (MW) request.

Signature: _____ Date: _____

Section 2: To be completed by licensed treatment provider:

The above named student has requested a Medical Withdrawal (MW) from Miami University, claiming to have had a condition preventing them from meeting the expectations of a student during the above indicated term. The student reports that you evaluated or treated them for that condition during that time period. Please complete in its entirety the following information regarding that condition, sign, and forward to the Office of the Dean of Students at the address noted below.

Provider's Name: _____ Provider's Title / Degree: _____

Provider's Area of Medical / Mental Health Specialization: _____

Office Address: _____

Office City, State and Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Part A: Your assessment and treatment of the student:

1. ☐ Medical in nature ☐ Psychological in nature
   ☐ Drug / alcohol concerns ☐ Other: _____

2. Date(s) of treatment / assessment: _____ to _____

3. Total number of sessions / appointments: Scheduled: _____ Attended: _____

4. Diagnoses related to the concerns of this request: _____

5. Medications prescribed related to the conditions of this request: _____

6. Status during the time period of the requested MW: ☐ Acute / critical ☐ Chronic / recurrent

7. Duration of the condition (period of time during which the student would not have been able to meet the expectations of a student):

_____

8. Prognosis (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

9. Will you continue to provide services for this student? ☐ yes ☐ no

10. If not, to whom will the student's care be transferred? _____

11. Other recommendations for follow up that you have communicated to the student:

_____

Part B: Your assessment of the student

1. Do you believe that this student is currently a danger to themselves? ☐ yes ☐ no
   Please explain:

   _____

2. Do you believe that this student is currently a danger to others? ☐ yes ☐ no
   Please explain:

   _____

Part C: Your recommendation

1. Do you believe that the student, due to the condition(s) described above, was unable to meet the expectations of a student during the time period of the requested MW? Please include additional elaboration and/or documentation as necessary. ☐ yes ☐ no
   Comments:

   _____

2. Do you support the granting of MW for the requested academic term? ☐ yes ☐ no
   Comments:

   _____

Signature of the provider: _____ Date: _____

Please complete in full and submit to:

Office of the Dean of Students, Miami University
110 Warfield Hall
Oxford, OH 45056
Telephone: (513) 529-1877, Fax: (513) 529-3445