



# Miami University Provider Return from Medical Withdrawal Form (Reinstatement)

*This form must be submitted to the Office of the Dean of Students by published deadlines for the term in which the student wishes to re-enroll. Late submission will result in a denial in processing your re-enrollment. The 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:

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 request to return from a Medical Withdrawal (MW).

Signature:

Date:

Preferred email:

Term (e.g. Fall, Winter, Spring, Summer) for which you are requesting return from MW:

Year for which you are requesting return from MW:

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## Section 2: To be completed by licensed treatment provider:

The above named student has previously been granted a Medical Withdrawal (MW) from Miami University, and is indicating readiness to return to full academic participation. The student reports that you evaluated or treated them while on Medical Withdrawal. Please complete in its entirety the following information regarding the student's current 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. Current diagnoses (if any) relevant to the MW:
5. Medications prescribed (if any) relevant to the MW:
6. Prognosis (check one):   ☐ Excellent      ☐ Good              ☐ Fair              ☐ Poor
7. Will you continue to provide services for this student?   ☐ yes              ☐ no
8. If not, to whom will the student's care be transferred?
9. 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. Based on your current evaluation, do you believe that the student is now able to meet the expectations of a student and engage in the rigors of academic and campus life?   ☐ 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