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 the request. Please type or print clearly in ink. **Please return to the student or upload it here:**

Section 1: To be completed by the student:

Student Name: Date of Birth: Banner ID#:

Term/Year (Fall, Winter, Spring, Summer) of Medical Withdrawal (MW) request: /

I understand and consent to the following: The information provided will be reviewed by the Office of the Dean of Students and by signing this form I am giving the Office of the Dean of Students (or its designee) permission to contact the healthcare provider listed below to verify the provided information. I also understand that the Dean of Students (or its designee) 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, indicating they experienced a condition that prevented them from meeting the expectations of a student during the indicated term/semester. The student reports that you evaluated or treated them for that condition during that time period. Please fully complete the form, sign/date, and return the form to the student (or upload it **here**).

Part A: Provider assessment and treatment of the student:

1. Is the evaluated condition primarily: Physical Health Mental Health Both
2. Specific date(s) of treatment/assessment during the requested term:
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. Duration of the condition (period of time during which the student would not have been able to meet the normal expectations of a student):
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. Treatment plan and other recommendations you have made to the student:

10. Do you believe that this student is currently a danger to themselves or others? yes no

    If yes, please explain:

Part B: Provider 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:

Part C: Provider information:

Office Address:

Phone: Email:

If the student is an F-1 or J-1 international student, government regulations require a U.S. Licensed Medical Doctor, Doctor of Osteopathy, or Licensed Clinical Psychologist to support the request.

Provider Name: Title/Degree:

Provider Signature: Date:

Licensed Supervisor Signature (If applicable):

License Number: Title/Degree:

Office of the Dean of Students at Miami University
110 Warfield Hall, Oxford, OH 45056
Phone: (513) 529-1877, Fax: (513) 529-3445 Email:
deanofstudents@MiamiOH.edu