TEMPLE UNIVERSITY

Return Authorization Statement

Petition for Excused Withdrawal

Revised 24-Oct-2017

Medical Provider's Clearance to Return to Temple University

Your patient seeks to return to Temple University after withdrawing in a previous semester as a result of a medical condition. As the medical doctor, psychiatrist, psychologist, or other licensed medical practitioner treating the student for the condition necessitating a withdrawal from classes, please complete the form and return it to the student. The completed form is required for the student to be considered for active status at the University. ***The student must sign and date this form before submission.*** *Thank you in advance for your assistance.*

Student Name: _____ TUID: _____ Withdrawal Term: _____

1) Did **you** provide medical treatment for the student named above? [] YES [] NO

2) Nature of the medical condition: _____

Is this a chronic condition? [] YES [] NO

3) Date treatment started: _____ Date treatment concluded (if applicable): _____

4) Did the treatment require prolonged absence (e.g., hospitalization, recovery, etc.)? [] YES [] NO

If yes, how long? _____

5) At the present time, is the student/patient ready to **safely** participate in:

(a) University classes as a full-time student? [] YES [] NO

(b) University classes as a part-time student? [] YES [] NO

6a) If you answered 'NO' to question 5, please explain: _____

_____

6b) If you answered 'YES' in question 5, does the student require special accommodation or assistance:

A. Ongoing counseling	[] YES	[] NO	[] UNSURE	**Tuttleman Counseling Services (TCS) : 215-204-7276**
B. Disability resource services	[] YES	[] NO	[] UNSURE	**Disability Resources & Services (DRS): 215-204-1280**
C. Excuse from physical activities	[] YES	[] NO	[] UNSURE	

D. Other course scheduling or participation accommodations (leave blank if unsure):

_____

_____

_____

_____

Your role in the treatment of this student/patient: [] Medical doctor **[]** Psychiatrist **[]** Psychologist **[]** Other _____

Print your full name clearly: _____Phone:_____

License number: _____ State: _____ Country: _____

Address: _____

Signature: _____ Today's date: _____

Student acknowledgement: By signing below, I certify that I understand my doctor's recommendation. If I need accommodation, I should address my request to Disability Resources and Services (phone: 215-204-1280).

Student signature: _____ Signature date: _____

PLEASE DO NOT SUBMIT MEDICAL DOCUMENTS WITH THIS FORM