CAMPBELL UNIVERSITY

Medical Withdrawal Physician Documentation

Student's Name *(last, first, middle)*: _____ **University ID#:** _____

The below information must be completed by a licensed medical provider or licensed mental health professional who administered care at the time of the illness or injury

Diagnosis (including any complications):

_____

_____

_____

_____

Date patient first visited you for this condition: ___/___/___

Did current condition result in a period of confinement? (Please Circle One): **Yes** **No**

If yes, where and when? **House: From** ___/___/___ **To:** ___/___/___

Hospital: From ___/___/___ **To:** ___/___/___

Was surgery performed? (Please Circle One): **Yes** **No**

If yes, on what date was surgery performed? ___/___/___

Was surgery Inpatient or Outpatient? (Please Circle One): **Inpatient** **Outpatient**

Did you prescribe the patient should stop attending classes? (Please Circle One): **Yes** **No**

If yes, date on which you advised patient to stop attending class: ___/___/___

If no, please complete the section below

Date student is released to return to classes: ___/___/___

Upon return to classes, will patient have any restrictions? (Please Circle One): **Yes** **No**

If yes, please describe: _____

_____

Physician's Signature: _____ **Date:** ___/___/___

Practice Name: _____ **Phone:** _____

Address *(Street, City, State, Zip)*: _____

Return Completed Form to: **Campbell University, Office of Student Life**
PO Box 95, Buies Creek NC 27506
Fax: 910-893-1540, Phone: 910-893-1540