



OHIO
UNIVERSITY

Division of Student Affairs
Housing & Residence Life

Medical Withdrawal Room & Board Cost Adjustment Request

Provider Report Form

This form must be completed by the **student's physician /mental health clinician/ service provider** and be sent directly from the provider to Housing and Residence Life by either fax (740.593.4089) or United States mail. If you are filling a tuition appeal with your college office it is not necessary to complete this form. If your tuition appeal is approved, Housing and Residence Life will adjust your housing to a weekly rate based on your check out date and your dining to the last date you accessed your meal plan. You can notify Housing and Residence Life that you are filing a tuition appeal by sending an email to housing@ohio.edu.

Housing and Residence Life
215 Living Learning Center
111 South Green Drive
Athens, OH 45701

Student Information (to be completed by student)

First Name: _____ Last Name: _____ Student PID: _____

Provider Information (to be completed by medical professional)

First Name: _____ Last Name: _____ License Number: _____

Licensed As/Licensure Type: _____ State of License: _____

Date of First Visit with Student: _____ Date of Most Recent Visit: _____ Total Visits (Last 3 Months): _____

Professional Assessment (to be completed by medical professional)

In order to objectively evaluate the need for a housing or dining withdrawal cost adjustment, provide detailed information related to the medical and/or psychological condition of the student. **Send a written assessment on clinical letterhead, including:** the initial on-set of the condition; the type, frequency and severity of symptoms; and treatments or medications necessary to alleviate symptoms. The written assessment and this document should be faxed or mailed as per the directions at the top of the form.

In addition, answer the following:

Does the student's condition/treatment require that they medically withdraw from the University?

Yes No

Is the student medically able to return to the University?

Yes No

On what date did the student first seek treatment for the condition that resulted in the request for a medical withdrawal?

Date: _____

Provider Signature

Signature: _____ Date: _____