RACKHAM GRADUATE SCHOOL
UNIVERSITY OF MICHIGAN

LEAVE OF ABSENCE OFFICE
915 E. Washington Street · 1120 Rackham Building · Ann Arbor, MI 48109-1070
Phone: 734-615-5670 · Secured Fax: 734-615-8042
E-mail: rackham.loa@umich.edu · http://www.rackham.umich.edu/current-students/policies/doctoral/

Leave of Absence Supplemental Information Form
Requesting a Leave for Medical Reasons
Initial request or extending a request

Students: Please complete the top section of this form and ask your health care provider to complete the form.

Health care providers: Please complete this form and submit it directly to Rackham Graduate School by fax or mail.

A leave of absence for medical reasons may be requested for a serious health condition that prevents continued progress toward the Ph.D. degree. A student may request a leave of absence for medical reasons for up to two consecutive Fall or Winter terms, or 12 consecutive months. A written recommendation from a qualifying health care provider is required to initiate, extend and return from a leave of absence for medical reasons.

To be completed by the student

Student's Name: _____ Student's UMID: _____

Date of Birth: _____ Student's Uniqname: _____

Please indicate the date and term that you are requesting a leave of absence to begin:

Term(s): ☐ Fall Term _____(year) ☐ Winter Term _____(year)

Leaves of absence are granted through the end of a term so expected return dates are at the beginning of the next term following the conclusion of your leave. Please indicate the month and year that you anticipate returning to active study:

☐ January 1 ☐ May 1 ☐ September 1 Year: 20_____

I authorize my treating health care provider(s) to provide any information necessary to facilitate my request for a leave of absence for medical reasons from my doctoral program at the University of Michigan including, but not limited to, drug or alcohol treatment records, lab/test results, x-rays, billing records and other documents that describe the diagnosis, treatment and prognosis rendered with regard to the medical condition(s) associated with this request for a leave of absence for medical reasons. I further authorize my treating health care provider(s) to communicate with a designated University of Michigan official regarding the treatment of my medical condition(s) associated with this request for a leave of absence for medical reasons. This consent will automatically expire when I am no longer on a leave of absence.

Student's Signature: _____ Date: _____

To be completed by the health care provider

Name of Health Care Provider: _____

Type of Practice/Specialty: _____

Title/Degree: _____

Health Care Provider's Address: _____

Telephone: _____ Fax: _____

Health care providers: Please return this form directly to the Rackham Graduate School's secure fax number: (734) 615-8042
If you have any questions, please contact Ida Faye Webster at (734) 615-5670

To be completed by the health care provider: Primary Diagnosis

Diagnosis: _____ ICD/DSM: _____

Date(s) you treated the patient for condition: _____

Treatment plan and present complications: _____

_____

Medication(s) and dosage(s): _____

_____

Approximate date condition commenced: _____

To be completed by the health care provider: Secondary Diagnosis

Diagnosis: _____ ICD/DSM: _____

Date(s) you treated the patient for condition: _____

Treatment plan and present complications: _____

_____

Medication(s) and dosage(s): _____

_____

Approximate date condition commenced: _____

To be completed by the health care provider

☐ I certify that the student named above has a medical condition with symptoms that cause clinically significant distress or impairment (mental or physical) in social, occupational or other important areas of functioning.

☐ I do NOT certify that the student named above has a medical condition with symptoms that cause clinically significant distress or impairment (mental or physical) in social, occupational or other important areas of functioning.

Comments: _____

_____

_____

Health Care Provider's Signature: _____ Date: _____

Privacy and Security Statement

We care about your privacy. The information we collect about you is private. Only people who have both the need and the legal right may see your information. We will only disclose your information for purposes of treatment, payment, business operations, appointment reminders, public health and safety and when we are required by law to do so.

Your personal information will be safeguarded. We are required to protect your personal information against reasonable anticipated threats and hazards to the security or integrity of the information.

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