

## 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 submitting to Secured Mailbox: <https://myumi.ch/rackhamloa> or Fax to: 734.936.3335.

*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: \_\_\_\_\_

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.