Confidential

INTERNATIONAL STUDENT

REQUEST FOR MEDICAL REDUCED or NO COURSE LOAD

WELLNESS CENTER
220 PAWTUCKET STREET, UNIVERSITY CROSSING, SUITE 300
LOWELL, MA 01854

phone: 978-934-6800
fax: 978-934-3080
email: Health_Services@uml.edu

To ensure confidentiality and privacy the **student** must complete and sign the Release of Medical Information section before submission of the document to their health care provider. All information will be kept strictly confidential and will be used only for the purpose of evaluating the student's request for reduction of course load and subsequent readiness to return to their academic work. The university reserves the right to impose conditions on return following a medical reduction of course load, which will include the submission of additional documentation from the student's health care provider and the student's consent to discuss the student's condition with University clinicians. RCL/NCL requests should be submitted prior to the start of a semester and must be submitted prior to the end of a semester. Please note that there are no adjustments to tuition or fees after the Add/Drop period.
This information will not become part of the student's academic record or health record but will be retained in a separate administrative file.

I, _____, have read and completed the ISSO Request for Reduced Course Load or No Course Load policy form and have reviewed the University of Massachusetts Lowell Purpose, Policy, and Procedure for a Request for Medical Reduced or No Course Load and have had the opportunity to have questions answered.

Date

_____
Student Signature

□ I have included my personal statement with my submission.

RELEASE OF MEDICAL INFORMATION

Last Name | First Name | MI | SiS ID#

Address

Date of Birth | Phone

Term/Year of Medical RCL/NCL

Year of Study (Fr, So, Jr, Sr, Grad) | Major

Date of last class attendance

I hereby authorize the release of information to the Directors of Health Services and/or Counseling Services at the University of Massachusetts Lowell for the purpose of determining my eligibility for an academic withdrawal due to medical circumstances. This information may include psychiatric care and/or treatment for alcohol and/or substance abuse.

Date

_____
Student Signature

For Administrative use:
- Date Received
- Approved
- Denied
- Pending

Revised 6/2023

Student Information

To be completed by medical provider.

(Per US State Department, medical provider must be MD, DO, or Clinical Psychologist.)

Last Name | First Name | Date of Birth

VERIFICATION FOR Reduction of Course Load (Please complete all sections. Incomplete forms will be returned for further information.)

Diagnose(s)

Diagnostic code(s) (ICD 10 or DSM 5)

Date of Diagnosis | Date of Hospitalization | Date of Surgery

Current Medication(s)

Currently under treatment? Yes ◯ No ◯

Dates of service: Initial visit | Last visit | Next scheduled visit

Please specify in detail how this problem interferes with the student's academic performance:

	No impairment	Mild impairment	Moderate impairment	Significant impairment	Severe impairment
Ability to attend class	☐	☐	☐	☐	☐
Ability to complete assignments	☐	☐	☐	☐	☐
Ability to prepare/study for exams	☐	☐	☐	☐	☐
Ability to complete labs, practicums, etc.	☐	☐	☐	☐	☐
Ability to work collaboratively with peers	☐	☐	☐	☐	☐
Ability to navigate a decentralized campus	☐	☐	☐	☐	☐

Thank you for your assistance in completing this document. Please provide your contact information. We may need to follow up for additional details or to verify any of the documentation.

Provider's Name | License #

Address | Phone

City | State | Zip Code | Fax

Date

Provider Signature / Credentials

Please return form to: Wellness Center Health Services
220 Pawtucket Street, Suite 300
Lowell, MA 01854

phone: 978-934-6800
fax: 978-934-3080
email: Health_Services@uml.edu