Readiness to Return after Medical Withdrawal Form
University of California, Santa Cruz

When requested by your college as part of the readmission process, this form should be sent by U.S. mail or FAX to the ***UCSC Student Health Center, Attn: CAPS Director; 1156 High St., Santa Cruz, CA 95064 or FAX: 831-459-5116****.*
It must be ***receive****d during the following date range for the readmission term:*
Fall readmission: ***August 1 – September 1****; Winter readmission:* ***November 1 – December 1****; Spring readmission:* ***February 1 – March 1***
Summer readmission: ***May 15 – June 15***

Student Name: _____ **ID#:** _____ **College:** _____

Readmission application term: ☐ Fall 20__ ☐ Winter 20__ ☐ Spring 20__ ☐ Summer 20__
(Readmission is not always required to attend in summer. Contact your college if you are unsure.)

Primary reason for medical withdrawal: _____

Which quarter did you withdraw for medical reasons?: _____

Name of Physician or Health Care Provider: _____

Office Address: _____

Telephone Number: _____

Authorization for Release of Information
I authorize the Health Care Provider above to provide the following information regarding my medical history and condition(s) to UCSC Student Health Center employees. I further authorize the Health Care Provider above to provide additional information regarding my medical condition and recommendations for ongoing treatment to the medical director or designee of the UCSC Student Health Center, if requested. I also acknowledge and agree that an additional evaluation by the UCSC Student Health Center medical director or his/her designee may be required.
Student Signature: _____ **Date:** _____

To the Physician or Health Care Provider:
This student is requesting readmission to UCSC after withdrawing due to a medical condition. Please respond to the following questions to the best of your ability, to address the student's readiness to resume studies. When completed, please return this form to the student, who will then submit it to the UCSC Student Health Center.

Please describe the treatment you provided to the student and how the condition that resulted in the student's medical withdrawal has changed.

_____
_____
_____
_____

Please indicate current medications and dosages if applicable:

_____ _____
_____ _____
_____ _____

Please describe your current treatment and any recommended ongoing treatment plan that will be required for the student to succeed academically. Please indicate who will be providing this treatment. (Please note-if there is an expectation that treatment will be provided by the UCSC Student Health Center (831-459-2211) or Counseling and Psychological Services (CAPS, 831-459-2628), student must contact us prior to finalizing the readiness to return process):

_____
_____
_____

Please choose one:
☐ The recommended treatment plan is currently in place
☐ The recommended treatment plan is not yet in place
☐ No ongoing treatment plan is necessary

I have treated the student for this condition and recommend (please choose one):
☐ Student is able to resume full-time studies beginning in the term listed above
☐ Student is able to resume studies beginning in the term listed above, but a part-time schedule is recommended until _____

Signature of Physician /Health Care Provider: _____ Date: _____

Degree: State: _____ License No.: _____