OFFICE OF THE VICE PRESIDENT FOR STUDENT AFFAIRS
JACKSONVILLE STATE UNIVERSITY

Licensed Provider Recommendation for Hardship Withdrawal

Provider Name:_________________________________Phone:________________

Address:____

Provider Credentials: Circle all that apply

- MD
- DO
- DNP
- Mental Health Professional, please specify:_____________________________

NPI#:__________________License Number:_______________State of Issue:______

Patient's Full Name:____

Patient's Date of Birth:____

Patient's Diagnoses with ICD-10 and/or DSM Codes:

____

____

____

How has the condition interfered with the patient's academic performance, safety or wellbeing at Jacksonville State University during the term for which the patient requested a hardship withdrawal?

Provide any additional information relevant to your recommendation for hardship withdrawal for the patient on office letterhead.

With my signature below, I provide my recommendation for hardship withdrawal from the______term or semester, 20_______at Jacksonville State University. The patient has given me permission to share the foregoing information with Jacksonville State University officials.

____________________________	_________________	___________
Signature	Stamp	Date

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