Eastern Kentucky University, Richmond Kentucky

Medical Leave of Absence Petition - Statement of Serious Illness or Injury

About medical leaves: A medical leave of absence (MLOA) may be available for students who have medical or psychological conditions with symptoms that severely limit their ability to perform their academic work. Medical leaves of absence are granted by the Registrar and Dean of Students and are based on the written recommendation of a medical or mental health provider who is currently involved with the student's care. If a medical withdrawal is approved all registration in any future semester class(es) will be removed.

To request a medical leave of absence (MLOA): All required information (see p.2) must be provided to the **Dean of Students** in the **Whitlock Building, Room 335** or mailed to **Dean of Students, Whitlock CPO 53, 521 Lancaster Avenue, Richmond, KY 40475-3150**. The information on the reverse side of this form must be provided by a medical or mental health professional, who is not a family member, before the request may be reviewed. Once this completed form and medical or mental health provider information is received, the Registrar and Dean of Students will review all information provided, and if approved, the leave will be processed through the Registrar's Office. During the period of medical leave, students must actively engage in appropriate treatment as recommended by their medial or mental health professional.

PROCEDURE:

1. Complete and sign Part I
2. Ask your medical or mental health practitioner to provide information per Part II (reverse side). This information must be submitted on the medical practitioner's official letterhead.
3. Submit the completed form and medical documentation to the Dean of Students office, Whitlock 540 - **before the beginning of final exam week** - of the term for which the Medical Withdrawal is requested.
4. Any meal plan will be cancelled within 48 hours of approval of MLOA.
5. Students in University housing must officially checkout within 48 hours of approval of MLOA.

PART I – TO BE COMPLETED BY STUDENT (PLEASE PRINT)

Name _____ Leave to Start: Fall of 20_____Spring of 20_____

EKU ID# _____ Class: Freshman Sophomore Junior Senior Graduate Level

Current (Local) Address_____

Permanent Address_____

Non-EKU Email Address _____Phone Number (Include Area Code) _____

Please list the date you last attended any classes: _____. *[If no date is given then the date of your withdrawal will be the date this form is signed.]*

PLEASE READ CAREFULLY BEFORE SIGNING BELOW:

I understand that:

- This form must be completed and medical documentation received for the request to be accepted and considered.
- I will be entitled to pro-rated housing and meal plan fees, if applicable.
- Registration in any future classes will be removed.
- I may have to **repay** all or part of any financial aid award received if I have received a financial aid check or if financial aid has been applied to my account (check with Financial Aid before submitting this form). *This can create a balance owed to the University.*
- This form and any medical documentation will be provided to the Office of Student Accounting Services as **partial documentation to be used** as a financial appeal. **If you desire a financial appeal you must provide an additional letter fully explaining your financial request**. Forgiveness of all of part of any balance owed to the University, as a result of the review, is **not** guaranteed.
- If I am an international student, approval of this request may affect visa status (check with the Office for International Education, if applicable, before submitting this form).
- I understand that I must complete the **Request for Return from Medical Leave of Absence (MLOA)** prior to my anticipated return to EKU. [If MLOA is approved, the Return from Medical Leave of Absence form will be sent to you by the EKU Registrar. It is also available online at the Registrar's website (http://registrar.eku.edu/withdrawal-information)].
- By signing this form, I authorize my health care provider to release necessary information to the University related to this request. Furthermore, I understand that my health care provider may be contacted for verification purposes.

Student Signature _____ Date _____

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PART I I – *TO BE PRESENTED TO MEDICAL/MENTAL HEALTH PROVIDER*

Dear Medical or Mental Health Care Provider,

STUDENT NAME _____

is requesting a medical leave of absence from all courses at Eastern Kentucky University, and has authorized you to release the requested information (see reverse side of this form). The information below is critical to deciding whether to approve this student's request for a medical leave of absence from EKU.

The needed information must be provided by a licensed medical or mental health practitioner, who is not a family member, and who is currently working with this student. The information must be presented on your office letterhead and submitted to: **Dean of Students, Whitlock CPO 53, 521 Lancaster Avenue, Richmond, KY 40475-3150** before the requested withdrawal will be considered.

Permanent or temporary serious illness or injury is the only acceptable basis for a medical leave of absence. You may be contacted to verify information provided.

Thank you for your assistance.

The following information must be presented on medical practice <u>letterhead and include the original signature of the provider.</u>

1. **Name of Licensed Health Care Provider.**
    a. **Street Address of Office or Clinic: City, State Zip Code**
    b. **Office Phone Number (with area code)**
2. **Describe the serious illness or injury that is preventing the student from completing classes.**
3. **Why is this illness/injury preventing the student from completing the academic term?**
4. **When did the symptoms of the illness/injury occur? *(Please specify dates).***
5. **Dates of examination for the condition claimed as the basis for medical withdrawal**
6. **When do you believe the student will be well enough to resume his/her academic program?**
7. **What treatment is the student undergoing?**
8. **Medical or mental health care provider must <u>sign and date</u> the letter with the above information.**