Part 1a: To be completed by the student:

Student Name: ___________________________ Cell phone #: ___________________________

UVM 95 # ___________________________ Semester of request ___________ Date completed ___________

(printed) (or netID and DOB)

I am requesting the academic adjustments outlined below due to health condition(s) or disability that have negatively impacted my ability to complete my coursework within the timeframe required. I have been receiving care or working with the following group regarding this condition:

☐ CHWB CAPS ☐ CHWB SHS ☐ SAS ☐ Other ☐ I’ve not yet been treated for condition

I agree to comply with the CONDITIONS FOR COURSE WITHDRAWALS AND INCOMPLETES. I understand that completing this form does not guarantee approval. I further understand that a designee of my college/school may need to discuss relevant aspects of my health with my health care provider(s), and I grant permission for them to share this information.

Student signature: ________________________________________________

Part 1b: To be completed by Student Services Office, in consultation with the student

Please circle home academic unit: CALS CAS CEMS CESS CDE CNHS COM GSB Grad Coll RSENR

<table>
<thead>
<tr>
<th>Course Prefix &amp; number</th>
<th>Course CRN</th>
<th>Instructor</th>
<th>Requesting Incomplete (I) or Withdrawal (WD)</th>
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<tbody>
<tr>
<td>ASL 001</td>
<td>12345</td>
<td>Smith</td>
<td>WD</td>
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Student Services Office signature: ________________________________________________

Printed Name: ___________________________ Date: __________________

Part 1c: To be completed by CHWB or SAS:

☐ This office confirms this student has a health condition/disability warranting consideration of incompletes or withdrawals as noted above, and is supportive of this request.

☐ This office cannot confirm this student has a health condition/disability that warrants medical consideration for academic adjustments requested above.

Signature of Certifying Official: __________________________________________ Date: __________

Printed Name: ___________________________ Office: SAS CAPS SHS
Health/Disability Modifications of Academic Requirements

Please use this form if you are requesting an incomplete or withdrawal in one or more courses for medical or disability reasons and have been working with CHWB Student Health, a UVM Medical Center Facility, SAS, or an outside medical provider. CHWB or SAS will review the information and offer a recommendation to your academic unit’s Student Services Office regarding the modifications requested. Your Student Services Office is the best source to help review what sorts of academic modifications (ie incompletes vs. course withdrawals) are possible and can support your needs.

Part 2: To be completed by the student

Student Name:____________________________________________________  DOB: ________________

UVM 95 #:_________________________________________________________ Cell phone #:________________________

1. What is the reason you are requesting an incomplete or withdrawal from one or more courses?

2. How has this health issue or disability impacted your functioning academically?

3. Please check the source of your medical/disability care related to this request, and specify the name/office of the health care provider (ie. “other: my GI doctor back home, Dr Williams”)

☐ CHWB Student Health:_____________________________________________

☐ CHWB CAPS: ______________________________________________________

☐ UVM Medical Center Emergency Dept, or hospitalization________________________

☐ SAS: ________________________________________________________________

☐ Other: **_________________________________________________________________

Student Signature:__________________________________________ Date: ____________

If your health care was conducted at CHWB, SHS will contact your treating provider(s) directly. If you were hospitalized at UVM Medical Center Hospital (or treated in the emergency room), your signature above gives CHWB permission to review your medical records in the University Hospital’s electronic medical record system.

**If you selected “other” above, please have your health provider complete part 3 of this form and return it to SHS (for medical requests) or SAS for (disability related requests). We will not be able to process your request until this information is received.

Please send completed form to: UVM Student Health Services OR UVM SAS

Attn: medical modification requests
CHWBMIF@uvm.edu
Fax: (802-656-8178)

OR

Disability Services
access@uvm.edu
Fax: (802) 656-0739
Health/Disability Modifications of Academic Requirements

Part 3: To be completed by the health care provider* treating or working with the student (please print)

Clinician’s Name____________________________________ Date:______________
(please print & include provider’s credentials)

Practice Name/Specialty:_____________________________________________________

Address:_________________________________________________________________________________

Phone:________________________ Fax:________________________

Student’s Name:__________________________________________________________ DOB:________________

1. Student’s diagnosis/disability condition:__________________________________________

2. Date of diagnosis of condition or exacerbation of a chronic condition:____________________

3. Description of the medical condition or disability and limitations it posed on the student’s ability to adhere to
the academic expectations:_____________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

4. When was (or will be) the patient able to resume baseline academic requirements:____________________

_______________________________________________________________________________________

Health Provider’s Signature*:________________________________________ Date:______________

Please or send completed form to the following UVM office that student requested:

UVM Student Health Services OR UVM Student Accessibility Services
Attn: medical modification request Attn: disability modification request
CHWBMIF@uvm.edu access@uvm.edu
Fax: (802-656-8178) Fax: (802) 656-0739

*health care provider completing this form must not be related to the student