University of Vermont Center for Health & Wellbeing (CHWB)
Request for health-related modifications in academic requirements

Part 1a: To be completed by the student:

Student Name: _______________________________ Date: __________________

UVM student ID #: __________________________ Semester/year of request: __________________

I am requesting the academic adjustments outlined below due to health condition(s) that negatively impacted my ability to complete my coursework within the timeframe required. I have been receiving care for this condition from:

☐ CHWB CAPS  ☐ CHWB SHS  ☐ Other  ☐ I have not yet been treated for this 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:  BSAD  CALS  CAS  CEMS  CESS

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

Student Services Office signature:________________________________________________________

Printed Name:________________________________________________ Date:_________________

Part 1c: To be completed by CHWB:

☐ CHWB confirms this student has a health condition warranting consideration of medical incompletes or withdrawals as noted above, and is supportive of this request.

☐ CHWB cannot confirm this student has a health condition that warrants medical consideration for academic adjustments requested above.

Signature of SHS staff completing this form:________________________________________________

Printed Name:________________________________________________ Date:_________________
University of Vermont  
Request for medically-related modifications in academic requirements

Please use this form if you are requesting an incomplete or withdrawal in one or more courses for medical reasons and have been receiving care from CHWB Student Health, a UVM Medical Center Facility or an outside medical provider. SHS will review the information and offer a recommendation to your academic unit Dean/Student Services Office regarding the medical modifications requested. Your Dean/Student Services office is the best source to help review what sorts of modifications are possible and best support your needs.

Part 2: To be completed by the student

Student Name:____________________________________________________  DOB:____________________

UVM student ID #:___________________________________  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 impacted your functioning academically?

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

☐ CHWB Student Health:______________________________________________________________

☐ CHWB CAPS:______________________________________________________________________

☐ UVM Medical Center Emergency Dept, or hospitalization________________________________

☐ Other:**___________________________________________________________________________

Student Signature:______________________________________________ Date:______________

If CHWB was the treating provider, we 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 to SHS. We will not be able to review your request until this information is received.

Please fax (802-656-8178) or deliver/send completed form to:

UVM Student Health Services  
Attn: medical modification requests  
425 Pearl St., Burlington, VT 05401
University of Vermont
Request for medically-related modifications in academic requirements

Part 3: To be completed by the medical provider treating the student

Provider’s Name_________________________________________________________   Date:_______________
(please print & include provider’s credentials)

Practice Name/Specialty:______________________________________________________________________

Address:____________________________________________________________________________________

Phone:_______________________________________   Fax:__________________________________________

Patient’s Name:__________________________________________________________ DOB:_________________

1. Patient’s diagnosis:________________________________________________________________________

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

3. Description of the medical condition 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:_____________________

   ______________________________________________________________________________________

Medical Provider’s Signature:______________ Date:________________

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