RACKHAM GRADUATE SCHOOL
UNIVERSITY OF MICHIGAN

LEAVE OF ABSENCE OFFICE
915 E. Washington Street · 1120 Rackham Building · Ann Arbor, MI 48109-1070
Phone: 734-615-5670 · E-mail: rackham.loa@umich.edu
Secured Mailbox: https://myumi.ch/rackhamloa or Fax to: 734.615.8042
https://rackham.umich.edu/navigating-your-degree/leave-of-absence/

Leave of Absence Supplemental Information Form
Returning from a Leave for Medical Reasons

Students: Please complete the top section of this form and ask your health care provider to complete the form.
Health care providers: Please complete this form and submit it directly to Rackham Graduate School by submitting to Secured Mailbox: https://myumi.ch/rackhamloa or Fax to: 734.615.8042.
A written recommendation from a qualifying health care provider is required to return from a leave of absence for medical reasons.

To be completed by the student

Student's Name: _____ Student's UMID: _____

Date of Birth: _____ Student's Uniqname: _____

I authorize my treating health care provider(s) to provide any information necessary to facilitate my return from a leave of absence for medical reasons to doctoral study at the University of Michigan including, but not limited to, drug or alcohol treatment records, lab/test results, x-rays, billing records and other documents that describe the diagnosis, treatment and prognosis rendered with regard to the medical condition(s) associated with my leave of absence for medical reasons. I further authorize my treating health care provider(s) to communicate with a designated University of Michigan official regarding the treatment of my medical condition(s) associated with the leave of absence for medical reasons. This consent will automatically expire when I am no longer on a leave of absence.

Student's Signature: _____ Date: _____

To be completed by the health care provider

Name of Health Care Provider: _____

Type of Practice/Specialty: _____

Title/Degree: _____

Health Care Provider's Address: _____

Telephone: _____ Fax: _____

To be completed by the health care provider: Primary Diagnosis

Diagnosis: _____ ICD/DSM: _____

Date(s) you treated the patient for condition: _____

Treatment plan and present complications: _____

_____

Medication(s) and dosage(s): _____

_____

Approximate date condition commenced: _____

Health care providers: Please return this form directly to the Rackham Graduate School's Secured Mailbox: https://myumi.ch/rackhamloa or Fax to: 734.615.8042. If you have any questions, please contact Ida Faye Webster at 734.615.5670

To be completed by the health care provider: Secondary Diagnosis

Diagnosis: _____ ICD/DSM: _____

Date(s) you treated the patient for condition: _____

Treatment plan and present complications: _____

_____

Medication(s) and dosage(s): _____

_____

Approximate date condition commenced: _____

To be completed by the health care provider

Do you have any special concerns that might impede the student's ability to function in a University setting?

_____

_____

_____

To be completed by the health care provider

☐ The student named above is ready to resume full physical and/or cognitive functioning as of _____(date).

☐ The student named above is ready to resume full physical and/or cognitive functioning with the following restrictions:

_____

_____

☐ I do NOT recommend the student named above resume activities at this time.

I am scheduled to see the student on_____(date).

Health Care Provider's Signature: _____ Date: _____

Privacy and Security Statement

We care about your privacy. The information we collect about you is private. Only people who have both the need and the legal right may see your information. We will only disclose your information for purposes of treatment, payment, business operations, appointment reminders, public health and safety and when we are required by law to do so.

Your personal information will be safeguarded. We are required to protect your personal information against reasonable anticipated threats and hazards to the security or integrity of the information.

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