

## Student Checklist for Returning from a Voluntary Health Withdrawal

- Notify the UNLV Health Withdrawal Committee (HWC) in writing that you wish to return to UNLV from your Health Withdrawal. Required forms are listed below and attached:

- No later than **April 1** for a proposed summer semester return
  - No later than **July 1** for a proposed fall semester return.
  - No later than **November 1** for a proposed spring semester return.

(Please note: Generally, a student returning from a voluntary health withdrawal will have taken one full semester off in order to receive treatment and gain stability.)

- Send each medical/mental health provider you have seen during your time away a copy of the **UNLV Medical /Mental Health Clearance Form**. Ask them to complete the form and mail it themselves **directly** to the UNLV Health Withdrawal Committee (see address listed below).
- Mail or fax to the UNLV Health Withdrawal Committee one original copy of the Authorization for Release of Protected Health Information from each of your medical/mental health providers.
- Contact the academic advising office for your college or school, Admissions, and Financial Aid to notify them of your intent to pursue reenrollment. Begin any academic planning you may need to do with them. Be sure to ask specifically what your college requires from you in order to return (e.g., documentation of activities while away).
- Graduate Students should contact the Graduate College at (702) 895-5773 or [GradRebel@unlv.edu](mailto:GradRebel@unlv.edu).
- Contact [vhw@unlv.edu](mailto:vhw@unlv.edu) or (702) 895-3370 if you have any questions about the process associated with returning from a voluntary health withdrawal.

Forms required to return from a Voluntary Health Withdrawal:

- Request to Return from a Voluntary Health Withdrawal (to be completed by the student)
- UNLV Medical/Mental Health Clearance Form (to be completed by each medical/mental health provider you have seen during your time away).
- Authorization for Release of Protected Health Information for each of your medical/mental health providers (to be completed by the student).

If your documentation is not received by the deadlines specified above, consideration of your application to return from a Voluntary Health Withdrawal may be postponed until a later semester. Documentation is reviewed as it is received; therefore, it is to your benefit to submit your materials as early as possible.

Please send all correspondence to:

UNLV Voluntary Health Withdrawal Committee  
Box 452005  
4505 S. Maryland Parkway  
Las Vegas, NV 89154-2005

Phone: (702) 895-3370 / Fax: (702) 895-4316

## Request to Return from a Voluntary Health Withdrawal

I have read the information above and have asked for any needed clarification and explanation. I understand the required conditions of return and the deadlines involved in returning from a Voluntary Health Withdrawal. I accept these conditions and deadlines as part of my responsibilities in taking a Voluntary Health Withdrawal from UNLV. I understand that my signing this form does not guarantee that I will receive authorization to return from Voluntary Health Withdrawal.

**Written Request for Re-admittance to UNLV from a Voluntary Health Withdrawal (to be completed by student):**

Please provide details regarding outcome of treatment & leave of absence, as well as your current sense of well-being:

---

---

---

---

---

---

---

---

Please tell us what type of support you will seek or require once re-admitted to the university (i.e. – medical check-ups, counseling, academic advising, tutoring, etc.):

---

---

---

---

---

---

---

---

Signature of Applicant:

Printed Name of Applicant:

---

---

Date \_\_\_\_\_

Applicant contact information:

**Mailing Address:**

Student's NSHE # \_\_\_\_\_

---

Major \_\_\_\_\_

---

For which semester are you applying for re-admittance to UNLV?

**Telephone:** \_\_\_\_\_

Fall       Spring       Summer

**Email** \_\_\_\_\_

## UNLV Medical/Mental Health Clearance Form

Page 1 of 2

Dear Clinician,

Please fill out this form as completely as possible. The information you provide will be utilized by the Voluntary Health Withdrawal Committee at UNLV to determine if the student under your care is able to return to their academic work and have the best possible chance of being successful in their academic pursuits, while maintaining optimal physical/mental health, following an approved Voluntary Health Withdrawal. Please attach additional pages if necessary to include documentation that will further assist us in rendering our decision and in planning for any support services for the student once they return to campus.

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_

Total number of medical or counseling appointments: \_\_\_\_\_

Description of patient/client treatment and progress: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last appointment: \_\_\_\_\_

Current Diagnosis(es): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Based on the above, please provide your professional judgment in response to the following questions regarding the student named above.**

Do you believe the student is ready to return to academic studies at UNLV from their Voluntary Health Withdrawal and function successfully?    Yes       No       Unable to determine

Please provide brief rationale: \_\_\_\_\_

If yes, please choose one option below:

Ready to carry a **full** course load     **OR**    Ready to carry a **reduced** course load

If reduced course load was selected, please describe rationale: \_\_\_\_\_

\_\_\_\_\_

# UNLV Medical/Mental Health Clearance Form

## Assessment of risk factors for student under your care:

ASSESSMENT	NONE	LOW	MODERATE	HIGH
Medical instability	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Suicidal behaviors	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Self-injurious behaviors	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Violent behaviors	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Substance abuse	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Disordered eating and/or compensatory behaviors	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Non-compliance with treatment	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Other: _____	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High

Please describe details if "High" or Moderate" selected above: \_\_\_\_\_  
\_\_\_\_\_

How might the student's current condition or side effects from treatment impact his or her academic functioning?

\_\_\_\_\_  
\_\_\_\_\_

Please describe any recommended academic accommodations, if applicable: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current treatment recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Clinician's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Clinician Name (please print/type)**

**SEND TO:**

\_\_\_\_\_  
**Clinician's License Type, Number, State (REQUIRED)**

This completed form and a Release of Information should be sent to:

**Mailing Address:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fax (702) 895-4316**  
OR  
UNLV Voluntary Health Withdrawal Committee  
Box 452005  
4505 S. Maryland Parkway  
Las Vegas, NV 89154-2005

**Telephone** \_\_\_\_\_

Phone (702) 895-3370

**Fax** \_\_\_\_\_



UNIVERSITY OF NEVADA, LAS VEGAS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(to be completed at time of request for voluntary health withdrawal return)

I, \_\_\_\_\_, authorize the following agencies or persons:
(Student Name)

Agency / Person where information is released from:

Agency / Person where information is released to:

Agency/Person Name, Title, Organization

Address

City, State, Zip

UNLV Health Withdrawal Committee
Box 452005
4505 S. Maryland Parkway
Las Vegas, Nevada 89154-2005

Phone (702) 895-3370
Fax (702) 895-4316

I authorize the release of the following information: All related medical and psychological information.

For the purpose of: Providing documentation for a Voluntary Health Withdrawal from UNLV.

This release is effective on \_\_\_\_\_ and expires one year from this date.
(Signature Date)

I understand that I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.

Signed:

Student Signature Required

Street Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Notice: This information has been disclosed from records that are confidential. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limit of this release.