Student Checklist for Returning from a Voluntary Health Withdrawal

☐ Complete and send back each of the following forms:

- ☐ Request to Return from a Voluntary Health Withdrawal
- ☐ UNLV Medical/Mental Health Clearance Form (2 pages)
- ☐ Authorization for Disclosure of Patient Health Information

☐ Ask each relevant medical/mental health provider(s) you have seen during your time away to fill out the **UNLV Medical /Mental Health Clearance Form**. Ask them to complete the form and send it **directly** to the UNLV Health Withdrawal Committee (see link and fax number listed below).

☐ Complete and send back an Authorization for Disclosure of Patient Health Information for each of your providers for the Voluntary Health Withdrawal Committee to contact your providers as necessary to complete the return.

☐ Contact your academic advisor, 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.

☐ Contact vhw@unlv.edu or (702) 895-0136 if you have any questions about the process associated with returning from a voluntary health withdrawal.

Please note: Generally, a student returning from a Voluntary Health Withdrawal will have taken at least one full semester off in order to receive sufficient treatment and gain stability.

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 VHW Secure File Submission Form

Email: vhw@unlv.edu
Phone: (702) 895-0136 / 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 Legal and Preferred Name of Applicant:

_____

Date _____

Student's NSHE # _____

Major_____

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

Fall ☐ Spring ☐ Summer ☐

Applicant contact information:

Mailing Address:

_____

_____

_____

Telephone: _____

Email _____

UNLV Medical/Mental Health Clearance Form

Dear Clinician,
The information you provide will be utilized by the Voluntary Health Withdrawal Committee at UNLV, staffed by health and mental health professionals, to determine if the student under your care is able to successfully return to their academic pursuits following an approved Voluntary Health Withdrawal.

Date: _____

Student Name: _____

Total number of medical appointments: _____

Total number of counseling appointments: _____

Description of treatment and progress: _____

_____

_____

Date of last appointment: _____

Current Diagnosis(es): _____

_____

_____

Current treatment recommendations: _____

_____

_____

Assessment of risk factors for student under your care:

ASSESSMENT	NONE	LOW	MODERATE	HIGH
Medical instability				
Mental Health Instability				
Suicidal behaviors				
Self-injurious behaviors				
Violent behaviors				
Substance use				
Psychosis				
Disordered eating and/or compensatory behaviors				
Non-compliance with treatment				
Other:_____				

UNLV Medical/Mental Health Clearance Form

If "moderate" or "high" was selected above, please explain the risk factors:_____

_____

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

_____

_____

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: _____

_____

_____

Would this student benefit from academic accommodations? (Please circle one) **Yes** **Not Needed**
If you select yes, the student will be referred to the UNLV Disability Resource Center.

_____ _____

Clinician's Signature **Date**

_____

Clinician's Printed Name (REQUIRED)

_____

Clinician's License Type, Number, State (REQUIRED)

If you have a clinical supervisor, they must sign and add their license number.

Mailing Address:

_____

_____

_____

Telephone _____

Fax _____

SEND TO:

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

Fax (702) 895-4316

OR

UNLV VHW Secure File Submission Form

Phone (702) 895-0136

UNLV Voluntary Health Withdrawal Committee

UNLV Voluntary Health Withdrawal Committee
4505 Maryland Parkway / Box 452005, Las Vegas, Nevada 89154-3020
(702) 895-0136 | FAX (702) 895-4316

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

(For purposes other than treatment, payment or health care operations)

Name: _____ **DOB:**_____ **NSHE #:**_____

Phone No. to contact you: _____

I HEREBY AUTHORIZE INFORMATION TO BE RELEASED:

FROM:	**TO:**
Name/Agency: _____	**Name/Agency:**_____
Address: _____	**Address:**_____
Phone: _____	**Phone:**_____
Tax: _____	**Tax:**_____

☐ **Allow mutual disclosure between agencies listed above**

PURPOSE FOR RELEASE: _____

INFORMATION TO BE RELEASED (Include Date of Service):

☐ Last pap report

☐ Office/Consult Notes

☐ X-ray reports (specify): _____ ☐

Lab reports (specify): _____ ☐

Immunizations (specify): _____ ☐

Other (specify): _____

SPECIFIC AUTHORIZATION: The undersigned acknowledges, agrees, and understands that any health information released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or substance abuse. My signature below authorizes release of all such information.

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization **expires one year from date of signature.**

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations. I understand if I do not authorize the release of my full health record, the recipient will be notified that only a limited health record is provided per patient request. A provider will not require me to sign an authorization as a condition of further treatment. I understand that the information used or disclosed pursuant to this authorization should not be re-disclosed without the written authorization of the patient. The university, the Student Wellness Center (Student Counseling and Psychological Services, Student Health Center, FAST Center), its employees, officers, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Legal Representative: _____ **Date:**

Print Name of Legal Representative: _____ **Phone No.**

Legal Representative Relationship to Patient: ☐ Parent ☐ Legal Guardian (Attach documentation of guardianship)

Disclosure Information

Date Disclosed: _____ PHI Sent to Requestor Via: ☐ Fax; ☐ Mail; ☐ Pick Up Box; ☐ Given to Patient; ☐ Secure Message Pages

Prepared: Type of PHI Disclosed: