Lehigh Carbon COMMUNITY COLLEGE

Office of Registration/Student Records
4525 Education Park Drive, SSC 122
Schnecksville, PA 18078
Phone: 610-799-1171 | Fax: 610-799-1173

Request for Medical/Mental Health Withdrawal

Physician/Mental Health Professional Form

Please return this form, completed by a licensed Physician/Mental Health Professional, to address above. This form is not required to submit a request for Medical/Mental Health Withdrawal, but may be submitted for the purposes of providing additional information.

STUDENT TO COMPLETE

I authorize my physician/mental health professional to release the information requested for my withdrawal from Lehigh Carbon Community College for this current semester. I understand that the information will be handled in a confidential manner and in compliance with HIPAA.

Patient Name:_____ ID#:_____

Student Signature:_____ Date:_____

PHYSICIAN / MENTAL HEALTH PROFESSIONAL TO COMPLETE

Diagnosis:

Date of onset:_____

Dates under your care for this specific illness:_____

Date(s) of hospitalization, if applicable:_____

Effect(s) the condition has on the student's ability to perform academically:

Prognosis:_____

Treatment plan:_____

PLEASE PRINT

Name of Physician/Mental Health Professional:_____ Phone:_____

Address:_____

Signature of Physician/Mental Health Professional: _____ Date:_____

Professional License ID #:_____