SOUTHERN UNION STATE COMMUNITY COLLEGE
LICENSED PROVIDER RECOMMENDATION FOR CATASTROPHIC WITHDRAWAL

Provider Name: _____

Phone: _____

Address: _____

Provider Credentials: (Circle all that apply.)

MD

DO

DNP

Mental Health Professional, please specify:_____

National Provider Identifier Number (NPI):_____ License Number:_____

State of Issue: _____

Patient's Full Name: _____

Patient's Date of Birth: _____

Patient's Diagnoses with ICD-10 and/or DSM Codes:

_____

_____

How has the condition interfered with the patient's academic performance, safety, or wellbeing at Southern Union State Community College during the term for which the patient requested a Catastrophic Withdrawal?

_____

_____

Provide any additional information relevant to your recommendation for Catastrophic Withdrawal for the patient on official letterhead.

With my signature below, I provide my recommendation for Catastrophic Withdrawal from the _____ semester, 20_____at Southern Union State Community College. The patient has given me permission to share the preceding information with Southern Union State Community College officials.

_____ _____

Licensed Provider Printed Name and Signature Date