BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

Provider Re-enrollment Form - Following a Withdrawal

REVISED 11/2022

Students with multiple treating providers may be required to submit a provider re-enrollment form from each of the treating providers.

Please complete thoroughly and legibly

Today's Date: ______________________ **Withdrawal Type: Medical / Psychological**

Student Information:

Student Name	**University B#**	**Date of Birth**	**Status**	**Student Phone Number**
			Undergraduate or Graduate	

Provider Information:

Name	**Credentials**	**License Number**	**Business Address and Phone and Fax Numbers**

Withdrawal Information:

Withdrawal Semester *(circle one)*:	*Spring* *Fall* *Year:*__________
Withdrawal Diagnosis:	
Circumstances leading to withdrawal:	
Desired return semester / session *(circle one)*:	*Spring* *Summer* *Fall* *Winter* *Year:*___________

Treatment and Re-enrollment Information: ***Completion of this section implies that it is the provider's professional opinion that the student is safe and able to return and function as a student at Binghamton University.***

Appointment Information:	Date of initial appointment	Date of last appointment
	Total # of appointments since initial appointment	Total # of appointments since withdrawal
Current Diagnosis [this should address the condition for which the student took the withdrawal]:		
Since withdrawal, evidence of demonstrated functional improvement includes:		
Concerns regarding the patient's safety:		
Concerns regarding the patient's ability to function as a student at Binghamton University:		

Maximum course load recommendation *(circle one)*	Full time (12+ credits undergrad. students / 8+ credits graduate students) *OR* Part-time (< 12 credits undergrad. / < 8 credits graduate students)

Please indicate which offices, that provide services and support, would be beneficial for this returning student:

____ Decker Student Health Services *(medical/psychiatric services)*
____ Service for Students with Disabilities *(academic accommodations & support)*
____ University Counseling Center - Treatment Coordination *(on-campus counseling and / or off-campus referral support)*
____ Dean of Students – CARE (***C***onsultation, ***A***dvocacy, ***R***eferral, ***E***ducation) Team *(care coordination & support)*
_____ Dining Services – Dietitians *(nutrition and special dietary needs)*
_____ Other

Treatment Recommendations *(appointment type, frequency, medication needs, living arrangements, etc.)*	
Does the patient plan to continue care through your office during requested semester reenrollment?	YES NO
- If No, what is the patient's plan for the treatment recommendations *(e.g. off-campus provider).*	
- Identify the name of the provider/office where student's treatment recommendations will be addressed,	
Other information that would be helpful.	

Submissions missing the required release of information are subject to denial

Student Name: ______________________________ Student B#: ____________________

Provider Name: ______________________________

Provider Signature: ______________________________ Date Signed: ____________________

Students: Upload this form, along with the Release of Information form, to the BU Health and Counseling online portal.

- Go to https://binghamton.medicatconnect.com/
- Indicate you are from Binghamton University. Sign in using your University username and password.
- Go to the UPLOADS section of the portal.
- Upload the completed form using the option "Withdrawal/Re-enrollment Forms." [[Note that forms uploaded using the incorrect option may lead to the form not getting reviewed.]

Please be aware that the re-enrollment process can take approximately 3 weeks to complete.
For any questions, please call Decker Student Health Services at 607-777-2221 or the University Counseling Center at 607-777-2772.