Oakland University
STUDENT REQUEST FOR RE-ENROLLMENT FORM
(For Medical Withdrawals Only)

Name:_____

Mailing Address:_____

_____

Phone:_____ Student I.D. Number:_____

Withdrawal Date:_____ Re-enrollment Term:_____

Treating psychiatrist/licensed psychologist contact information:

Name:_____

Phone:_____

I hereby submit my request for re-enrollment. I understand that I can be required to have a psychological evaluation completed by a psychiatrist or licensed psychologist prior to consideration of the request.

I understand that the recommendations as stated in the psychological evaluation may be used by officials at the University when considering my request for re-enrollment.

I give my consent that my treating psychiatrist, or other physician, or licensed psychologist may release pertinent information to the Dean of Students Office needed for the evaluation of my re-enrollment request. I hereby agree that a photocopy or fax of this release is a legal equivalent of the original document.

I understand that the university is not responsible for any costs related to my request for re-enrollment.

_____ _____

Student Signature Date

Please submit completed form to:
Dean of Students Office (248) 370-3352 Office
Oakland University (248) 370-4250 Fax
144 Oakland Center
Rochester, MI 48309