



MEDICAL WITHDRAWAL REQUEST FORM

Date: _____

Student Name: _____ Student DOB: _____

Student ID/SS#: _____ Student Signature: _____

I am requesting a Full _____ or Partial _____ withdrawal

for the _____ semester year _____.
Intersession/Spring/Summer/Fall

The last day you attended classes was: _____

If you are requesting a PARTIAL withdrawal please list the classes you wish to withdraw from below:

Please attach all corresponding medical documentation from physician(s) stating the condition/problem in which the Medical Withdrawal is being requested.

Once the information is complete and turned in to Health Services, the Director will review and make her recommendation to Student Services. Completing this form does not constitute a tuition refund. Please check the Bursar's webpage for information on their Tuition Refund Appeal process.

If you require assistance please contact Health Services at 292-2018 between the hours of 8:45am & 4:45pm Mon-Fri.

Thank you,

Health Services

For Office Use Only

Director's Approval Signature: _____ Date: _____