

**Partial Medical Withdrawal
Health Provider Report**

Name:	<input type="text"/>	CSUN Student ID:	<input type="text"/>
Term:	<input type="text"/>	Year:	<input type="text"/>
		Major:	<input type="text"/>
Phone:	<input type="text"/>	CSUN email:	<input type="text"/> @csun.edu
		Alternative email:	<input type="text"/> @

The above named student is requesting a medical withdrawal from *some* of his/her courses at California State University, Northridge and has authorized you to release information. A Statement of Disability must be completed by a licensed health care provider and submitted before the requested partial medical withdrawal can be considered.

In order for us to make a well informed decision as to whether we can grant this partial medical withdrawal request, we ask you to provide us with as much detail as possible regarding the clinical picture of the student's disability. Feel free to use the back side.

Name of Health Care Provider: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: () _____

1) Describe the serious illness or injury that is preventing the student from completing all of his/her classes.

2) From your clinical perspective, is there rationale for the student to withdraw from only part of, but not all of his/her classes, yes or no?

3) If yes, please state your clinical rationale with some detail.

4) Dates of examination for the condition claimed as the basis for partial medical withdrawal:

5) When do you believe the student will be well enough to resume his/her full time academic program?

License #: _____ **Signature:** _____ **Date:** _____

Authorization to Disclose Health Information

1. I authorize the use or disclosure of my health information as stated on this form to professional staff at the Student Health Center, University Counseling Services and the Office of Undergraduate Studies at California State University, Northridge, 18111 Nordhoff Street, Northridge, CA 91330.
2. I understand that the information in my health record may include general information about physical, behavioral, or mental health, and/or about treatment for alcohol and drug abuse.

Student Signature _____ Date _____ Semester(s) _____