

PETITION FOR COMPLETE WITHDRAWAL FOR MEDICAL REASON

Section A

Name: _____ Student ID# _ _ _ - _ _ _ - _ _ _

Address _____ City: _____ Zip: _____

Phone: (____) _____ email: _____ @ _____

Female _____ Male _____ Other: _____

Freshman _____ Sophomore _____ Junior _____ Senior _____ Grad _____

Other: (explain) _____

Units enrolled in this semester: _____

Number of previous medical withdrawals: _____

Semester(s) previous medical withdrawal taken: _____

Semester from which you wish to withdraw: _____ Year: _____

Have you taken any final examinations this semester? Yes No

***What was the last day you participated in an academic related activity such as classroom attendance, turned in an assignment or took a test for which you received a grade, emailed your professor, visited a counselor or advisor, responded on a classroom blog, attended an on-campus activity, etc? _____/_____/_____
MONTH DAY YEAR

*****PLEASE NOTE: ADMISSIONS AND RECORDS WILL USE THIS DATE AS YOUR WITHDRAWAL DATE. THE WITHDRAWAL DATE MAY AFFECT YOUR FINANCIAL SITUATION AND MAY RESULT IN THE REDUCTION OR CANCELLATION OF YOUR FINANCIAL AID FOR THIS SEMESTER. YOUR PROFESSOR WILL BE NOTIFIED BY CHECKING THE ROSTER IN SOLAR.**

I have read and understood the above.

Student's signature: _____ **Today's Date:** _____
(Signature of parent or guardian if student is a minor) _____

Section A continued

Name: _____ Student ID.# _____

Please circle yes or no for each of the following items that apply:

1. Receiving financial aid Yes No
PLEASE NOTE: Financial Aid Recipients: Please check with Financial Aid before completing this application to ensure you understand the financial impact of this withdrawal. Your Financial Aid may be reduced or canceled and/or you may be asked to re-pay Financial Aid dollars to CSUN.

2. Registered with Center on Disabilities Office Yes No

3. Registered with International Students Office Yes No
PLEASE NOTE: International Students: Please check with the International Students Office before completing this application to ensure you understand the Immigration/Visa impact of this withdrawal. You may lose your eligibility to stay in the United States.

4. Reside in Campus Housing Yes No
PLEASE NOTE: Housing Residents: Please check with Housing before completing this application to ensure you understand the financial impact of this withdrawal on your Housing Bill. You may be not be able to get your Housing payments refunded for this semester.

5. Registered with Veterans Services Office Yes No
PLEASE NOTE: Registered Veterans: You must notify the Veterans Services Office immediately upon completing your application.

6. Purchased insurance through Associated Students Yes No
PLEASE NOTE: Policy holders: Please visit www.csuhealthlink.com to explore the impact of this withdrawal on your insurance policy.

Student's signature: _____ **Today's Date:** _____
(Signature of parent or guardian if student is a minor)

Section B

Name: _____ Student ID.# _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please be assured that the record of correspondence from your provider will be kept in your confidential medical record at the Klotz Student Health Center. If sufficient information to make a decision about the withdrawal is not provided in the letter/note, the Klotz Student Health Center may contact your provider.

I hereby authorize my provider _____ to
NAME OF MEDICAL PROVIDER and degree

release any medical information contained in my records regarding this medical withdrawal to the CSUN Klotz Student Health Center.

Student's signature: _____ **Today's Date:** _____
(Signature of parent or guardian if student is a minor)

This permission expires on Date: _____ **Provider phone #:** _____

Instructions To Medical Provider:

INFORMATION REQUIRED IN A LETTER. This is not a form to fill out.

Your patient _____ (STUDENT NAME) has applied for a withdrawal for medical reason from this University. This means the student receives either no credit for the semester or no credit for the classes being dropped. If the request is for retroactive action, existing failing grades are removed, and there is no penalty to the student's academic record. We need your help to evaluate this request. The student has signed a release for this information which will be kept in the student's confidential medical record in the Klotz Student Health Center.

The following information is required on your official letterhead stationery, which should include date of the letter, your full name, title, address, telephone number, and signature.

1. Diagnosis, nature of illness, and complications.
2. In your opinion, does the student's medical condition prevent them from progressing and/or completing class(es)?
3. Date student will be able to return to classes.