Medical Withdrawal for Undergraduate Students: Student Consent and Health Care Provider Guidelines

Student Information and Release: Complete this form **any time** after classes begin and retroactively to request a partial or complete medical withdrawal. Give this completed form to your health care provider. Then email the form together with your provider's letter to Undergraduate Studies at ugs@csun.edu from your CSUN email address. **After the deadline to drop classes online**, you must also submit the Late and Retroactive Change in Academic Schedule Request for Undergraduate Students (.pdf) with required signatures to the appropriate campus administrator as directed on the form. Then email all forms, the health care provider's letter, and supporting documents to ugs@csun.edu from your CSUN email address or deliver in person to Valera Hall (VH) Room 215. Helpful: How to File a Form

Name: _____ CSUN Student ID: _____

Current Term & Year (e.g., Fall 2022): _____ Major: _____

Phone: _____ CSUN Email: _____**@my.csun.edu**

Student's Authorization to Disclose Health Information

1. I authorize, for the term(s) indicated below, the use or disclosure of my health information in the medical documentation provided to professional staff in Student Affairs (Student Health Center, University Counseling Services, Disability Resources and Educational Services) and Academic Affairs (college offices, department offices, 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 treatment for alcohol and drug abuse.
3. I understand that if sufficient information to make a decision about the withdrawal is not provided in the letter, the reviewing campus administrator may contact my health care provider.

I authorize the release my health information for the term(s) and year(s) indicated below (check all that apply):

☐ Fall Year: _____ ☐ Winter Year: _____ ☐ Spring Year: _____ ☐ Summer Year: _____

Student Signature: _____ Date: _____

Health Care Provider Guidelines:

The above-named student is requesting a medical withdrawal from ***some or all*** of their courses at California State University, Northridge and has authorized the release of medical information. A letter (on letterhead) by a licensed health care provider verifying the student's inability to continue class(es) must be submitted with the petition before the requested medical withdrawal can be considered. All correspondence from the student's health care provider will be kept confidential.

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

Please ensure the following information is addressed in the letter:

1. **Contact information of Health Care Provider: Name, Address, Phone number, and Practicing License Number.**
2. **Describe the serious illness or injury that is preventing the student from completing some or all of their classes.**
3. **From your clinical perspective, is there rationale for the student to withdraw from only part or all their classes?**
4. **If yes, please state your clinical rationale with some detail. Explain how the medical and/or psychological condition affects the class(es) the student is requesting to withdraw from.**
5. **Provide date(s) of examination for the condition claimed as the basis for medical withdrawal.**
6. **When do you believe the student will be well enough to resume their full-time academic program?**