

Medical-Psychological Withdrawal Request

Part A – To be Completed by the Student

Student Name: _____ Student #: _____

Address: _____

Phone: _____

Major _____ Academic Advisor: _____

Circle One: Full Withdrawal Partial Withdrawal

Date student notified institution of intent to withdraw: _____

Semester withdrawing from: _____

Please list courses from the semester listed above to be dropped exactly as listed in WEBADVISOR:

Reason for Medical/Psychological Withdrawal Request: _____

I understand that accepting a Medical-Psychological Withdrawal from the University means that I will:

- Accept recommendation to pursue on-going treatment with a licensed health or mental health professional to address the issues which led to the withdrawal for a period of time specified by the Director of Counseling Services or the Director of Health Services (usually at least 3 months to ensure my return to optimal functioning);
- Complete a “Return from Medical-Psychological Withdrawal” form and submit it to the Director of Student Health Services for medical conditions or the Director of Counseling Services for psychological/psychiatric conditions when I wish to re-enroll;
- Request that all professionals treating me for medical or psychological/psychiatric conditions during my absence from the university complete a “Community Provider Report Form” when I wish to re-enroll;
- Meet with the Director of Student Health Services or the Director of Counseling Services when I wish to re-enroll;

Further, I understand and accept any consequences that may occur due to my withdrawal from the University including changes in financial aid, residence, and health insurance. I understand that tuition refunds are determined by the policy published in the current University Catalog and University Housing refunds are determined by policy listed in the University Housing Licensing Agreement.

Student Signature

Date

Legal Guardian/Next of Kin Signature (if required)

Date

Part B – To be Completed by the Director of Student Health Services or the Director of Counseling Services

I have discussed this student’s medical or psychological status with him/her or with his/her next of kin when the student was incapacitated or unavailable.

_____ I agree that the student has a legitimate medical or psychological/psychiatric condition which warrants a Medical-Psychological Withdrawal from the University and is in the best interest of the student.

_____ I do **not** agree that the student has a legitimate medical or psychological/psychiatric condition which warrants a Medical-Psychological withdrawal from the University and is in the best interest of the student.

Signature

Date

Part C– To be Completed by the Provost (or designee)

_____ I grant a Medical-Psychological Withdrawal from the University.

_____ I do **not** grant a Medical-Psychological Withdrawal from the University.

Signature

Date

Part D– Offices to be Notified of Decision To be Completed by the Director of Student Health Services or the Director of Counseling Services

- Registrar
- Student Accounts
- Dean of Students
- Counseling Services
- Student Health Services
- Financial Aid
- Athletics
- Academic Advisor
- University Housing
- Veteran Services

Other: _____