REQUEST FOR MEDICAL WITHDRAWAL

University Withdrawal Policy includes a provision for a student who becomes seriously ill or injured, or is hospitalized and hence unable to complete the academic term, to request a medical withdrawal. To the extent possible, you are encouraged to consult with the instructor of each course you are withdrawing from. This medical withdrawal request is only valid for one academic term.

Student Name: ____________________________________________

CSUB ID: _______________________________________________

Email: ___________________________________________________

Phone: ___________________________________________________

Student Major: ____________________________________________

School: _________________________________________________

☐ TERM WITHDRAWAL  ☐ RETROACTIVE TERM WITHDRAWAL (past term)  ☐ INDIVIDUAL COURSE WITHDRAWAL

☐ FALL  ☐ WINTER  ☐ SPRING  ☐ SUMMER  YEAR: __________  LEVEL: ☐ Undergraduate  ☐ Graduate

Class Ref # (e.g. 88123)  Subject and Course Number (e.g. MATH 1020)  Section (e.g. 01)  Units  Instructor’s Name (printed)  Instructor’s Signature (Required)

Total Units Enrolled in Before Change: ________________ Total Units Enrolled in After Change: ________________

Reason for Drop: ____________________________________________________________

Advisor’s Name & Signature: (Required) ____________________________ Date: ____________________________

Advisor attests that s/he has reviewed the impact of this course/term/retroactive drop on the student’s academic progress, time to degree and unit load.

I have read and understand the instructions on the reverse side of this form. My signature below authorized my healthcare provider to release necessary information to the University related to this request. Furthermore, I understand that my healthcare provider may be contacted for verification purposes.

Student’s Signature: ____________________________________________ Date: ____________________________

REQUIRED APPROVALS AND SIGNATURES

Dean or Designee Approval: ____________________________________________ Date: ____________________________

(Required after Census Day, Term or Retroactive Term Withdrawal requests). Dean/Designee attests that student’s justification for Drop is appropriate per policy.

AVP, Enrollment Management Approval: ____________________________________________ Date: ____________________________

(Required after Census Day, Term or Retroactive Term Withdrawal requests)

Admissions & Records Office Use Only:

Processed By: ____________________________ Date: ____________________________

This is the official Admissions and Records Request for Medical Withdrawal Form and supersedes all and any previous forms from any CSUB department. (05.11.2018)
Part I – Student Information

Student Name: ____________________________________________________  CSUB ID: ____________________________

E-mail: __________________________________________________________  Phone #: ____________________________

Medical Withdrawal Physician Statement To Physician or Healthcare Provider:

__________________________________________________________ is requesting a medical withdrawal from his or
her classes at California State University, Bakersfield and has authorized you to release information in response to the
questions below. A Statement of Disability must be completed by a physician or licensed healthcare provider and
submitted to the CSUB Admissions and Records Office before the requested medical withdrawal can be considered.
Serious permanent or temporary illness or injury is the only acceptable basis for a medical withdrawal. You may be
contacted to verify information provided. Information contained in this form is considered private and confidential.

Part II – To be Completed by Physician or Healthcare Provider (Please Print)

______________________________________________________________  Phone: ____________________________________

Name of Physician or Healthcare Provider

Street Address: ______________________________________________________________________________________

City: __________________________________________ State: ___________ Zip: ______________

1. Describe the serious illness or injury that is preventing the student from completing the term and why.

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

2. When did this illness/injury occur?

_________________________________________________________________________________________________

3. Dates of examination for the condition claimed as the basis for the medical withdrawal.

_________________________________________________________________________________________________

4. When do you believe the student will be well enough to resume his/her academic program?

_________________________________________________________________________________________________

5. What treatment is the student undergoing?

_________________________________________________________________________________________________

Signature: ____________________________  Date: ____________________________  License #: ____________________________