CSU Bakersfield

California State University, Bakersfield
Office of Admissions and Records
Mail Stop: 47 SA, 9001 Stockdale Highway
Bakersfield, California 93311-1022
Tel. (661) 654.3036 | Fax. (661) 654.3389 | www.csub.edu/admissions

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:** _____
Last Name First Name Middle Initial *(Required)*

Email: _____ **Phone:** _____
(Required) *(Required)*

Student Major: _____ **School:** _____
(Required) *(Required)*

☐ **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: _____
(Required after Census Day, Term or Retroactive Term Withdrawal requests). Dean/Designee attests that student's justification for Drop is appropriate per policy. DATE

AVP, Enrollment Management Approval: _____
(Required after Census Day, Term or Retroactive Term Withdrawal requests) DATE

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)**

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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 #:** _____