



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: Last Name First Name Middle Initial CSUB ID: (Required)

Email: (Required) Phone: (Required)

Student Major: (Required) School: (Required)

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

FALL WINTER SPRING SUMMER YEAR: LEVEL: Undergraduate Graduate

Table with 6 columns: 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:



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 Registrar's 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.

Three horizontal lines for text entry.

2. When did this illness/injury occur?

One horizontal line for text entry.

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

One horizontal line for text entry.

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

One horizontal line for text entry.

5. What treatment is the student undergoing?

One horizontal line for text entry.

Signature: _____ Date: _____ License #: _____