

Student Request for Medical Withdrawal

Students wishing to pursue a medical withdrawal must first submit a standard term withdrawal.

Student's Full Name: _____ CWID: _____

Email Address: _____ Cell Phone: _____

Please check the box for the type of withdrawal you are requesting and indicate the term or semester(s) and year(s). For example, Fall 2015, Summer I 2015, Spring 2016, etc. Incomplete forms will not be processed.

	<p>Regular Medical Withdrawal (current term or semester). Submission and all documentation required by the end of business day of the last day of classes. Term or Semester Requested: _____</p>		<p>Retroactive Medical Withdrawal (previous term or semester made within sixty (60) days from the last day of the term/semester in question). Submission and all documentation required for previous term or semester within sixty (60) days of the end of business day of the last day of classes. If approved, effective date of withdrawal will be the last day of classes for the semester/term in question. Term or Semester Requested: _____</p>
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Describe how or why the condition(s) has/have interfered with your academic performance. _____

When did your medical-related concerns begin? Describe how these concerns evolved. _____

What was the last date you attended any of your classes and/or submitted assignments? _____

Did you provide any medical documentation to your teachers for the semester or term in questions? _____
If yes, please attach to this form.

Describe what campus based resources you utilized for the term or semester in question to assist you in support of academic success (i.e. Counseling Center, Office of Academic Success, Office of Disability Services, Dean of Students-Care and Wellbeing, Academic Dean's or Advising Offices, etc.). _____

Forms/documentation required to process this request can be found at www.shc.ua.edu.

With my signature below, I attest to the accuracy of the information given and:

- I understand that the Student Health Center and Pharmacy (SHC) may contact my healthcare provider(s) and other campus resources to collect additional information and/or to share information related to my request for a medical withdrawal or potential return to campus. I give full permission and consent to any such contact and information sharing/collection.
- I understand I am responsible for providing the form for medical documentation to the licensed medical provider who has treated me. I further understand that, if I am requesting a retroactive withdrawal and am currently enrolled or intending to be enrolled or registered an upcoming semester or term, I must

also submit the required paperwork seeking a return to campus simultaneously with this form. I understand that it is my responsibility to confirm that the additional required documentation in support of this request is delivered to the SHC according to the time requirements stated above.

- I certify that I did not take a final exam or complete a course(s) where no final exam was required for the semester in question and further understand having done so makes me ineligible for medical withdrawal.
- I acknowledge that, if I have questions regarding the financial implications of withdrawal, I will contact Student Account Services at **205-348-5350** prior to my submission of this paperwork.
- I understand that if my medical withdrawal request is approved and processed, I may owe a balance to the University. Furthermore, I understand that if I fail to pay any unpaid balance on my student account, I will be personally responsible for, and agree to pay, all costs and fees of collection, including late payment fees, transcript hold fees, interest, collection fees of third party collection agencies or attorneys (up to 40% of the principal, interest and late charges accrued prior to referral to such agency or attorney), court costs, and/or any other charges necessary for the collection of this debt.
- I understand that if I am registered for a future/upcoming term and I fail to provide appropriate medical documentation as specified in the University's Medical Withdrawal policy clearing me to return to UA, my future class schedule will be cancelled approximately a week prior to the beginning of the semester.

Signature: _____ Date: _____