

Idaho State UNIVERSITY

Health Center
921 S. 8th Avenue, Stop 8311 Pocatello, Idaho 83209-8311

Medical Withdrawal Documentation

A student who has a significant or severe personal medical condition, as determined by appropriate licensed medical professional, that precludes continued academic enrollment, must provide documentation as follows in order to be considered for withdrawal based on exceptional circumstances:

- A. "Application for Medical Withdrawal" form filled out
- B. Medical Provider Documentation for Medical Withdrawal. Student must sign that form and give the form to the medical provider for completion. Medical provider is defined as: Medical Doctor, Doctor of Osteopathy, Physician Assistant, Nurse Practitioner, Licensed Psychologist, or Licensed Professional Counselor.
- C. A brief statement in the student's words outlining the reason for requesting a withdrawal.

Letters from health care practitioners other than those listed above, for example, Registered Nurses, LPNs, Medical Assistants will not be acceptable documentation. The student is requested **NOT** to supply medical chart notes, hospital records, X-Ray reports or any documentation other than the forms requested above.

Once a student has been approved for withdrawal based on exceptional circumstances, the approval is final and cannot be rescinded at a future date for any reason.

Please submit the Application form, the brief statement and the letter from your medical provider to:

Medical Withdrawals

ISU Health Center
921 S. 8th Ave, Stop 8311
Pocatello, ID 83209
Phone (208) 282-2330
Fax (208) 282-4036

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Application for Medical Withdrawal

For students seeking withdrawal from all classes due to personal medical issues.

Name: _____ Bengal ID#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Major/Department: _____

Semester for which withdrawal is requested: Year ____ _Fall _Spring _Summer

_____ Date you last attended classes for the withdrawal semester

You may withdraw from classes on your own before the "last day to withdraw" (see academic calendar). This will result in a W on your transcript.

If you stopped going to class before the "last day to withdraw" AND you did not withdraw from the class, please explain why you did not withdraw before the "last day to withdraw."

If this is a request for a retroactive withdrawal more than one month past the end of the semester in which you are requesting a withdrawal, please explain what prevented you from requesting the withdrawal within one month of the end of the semester:

_____ Date of withdrawal from all classes associated with this medical withdrawal

I hereby petition for a medical withdrawal from enrollment in all classes for the current semester at Idaho State University due to my personal illness. I authorize ISU representatives to review my medical records and other documentation as necessary to determine my eligibility for a medical withdrawal and/or a refund of fees. I further authorize my medical provider to speak with University Health Services about any questions related to my personal illness. **I have discussed this withdrawal with my Academic Advisor and Financial Aid.**

Signature: _____ Date: _____

Documentation required:

- A. This form completed.
- B. A brief statement by you about your current circumstances. This is a paragraph outlining why you are seeking this withdrawal.
- C. Completed **Medical Provider Documentation for Medical Withdrawal** form faxed directly from your medical provider to University Health Services with a cover page from the provider's medical practice.

Keep a copy of A and B for your records.

Please submit this form A. and B. to:
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Medical Provider Documentation for Medical Withdrawal

IF FORM IS NOT COMPLETED IN IT'S ENTIRETY, STUDENT MAY BE DENIED A MEDICAL WITHDRAWAL

Date: _____

Dear Medical Treatment Provider:

I, _____, am requesting a withdrawal from all courses during the academic term _____, due to my personally significant illness or for severe medical reasons. Idaho State University requires that this form be completed by my medical treatment provider to support this withdrawal.

For the period for which I am requesting a withdrawal, please provide the following documentation on this form or another form and fax the form directly to University Health Services (208) 282-4036 with a cover page from your medical practice:

Dates of Treatment/Examination

Diagnosis

Additional information on the nature of the medical condition in sufficient detail to justify complete withdrawal from the student's term indicated above. Please complete all sections of this form:

- **A statement that you, as the treating medical provider, believe that the medical condition caused the student to be unable to participate in academic pursuits:**

- **Need for withdrawal from all classes and programs due to the medical reason(s) indicated:**

- **Date of onset of inability to perform academically:**

- **Expected duration of impairment:**

- **Anticipated date of ability to return to school and meet academic expectations:**

I give permission for my medical treatment provider to talk with University Health Services, about any questions we may have about the information contained herein.

Signed: _____ (Name of Student)

Date: _____

Signed: _____ (Name of Treatment Provider)

Printed Name of Treatment Provider: _____

Telephone: _____