

Idaho State  
**UNIVERSITY**

Health Center

921 S. 8<sup>th</sup> Avenue, Stop 8311 Pocatello ID 83209-8311

**Medical Provider Documentation for 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:

- **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 the Director of University Health Services, Dr. Ronald Solbrig (MD), about any questions he may have about the information contained herein.

Signed: \_\_\_\_\_ (Name of Student)

Date: \_\_\_\_\_

Signed: \_\_\_\_\_ (Name of Treatment Provider)

Printed Name of Treatment Provider: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax this completed form directly to University Health Services at (208) 282-4036.