MEDICAL WITHDRAWAL FORM

Date Received_____

NAME_____
(First) (Initial) (Last)

STUDENT ID NUMBER_____ **Phone**_____

CURRENT QUARTER_____ **LAST DATE OF ATTENDANCE**_____

MEDICAL REASON FOR WITHDRAWAL: (Explain circumstances and list the courses that you are requesting to be withdrawn from)

_____
_____
_____
_____
_____
_____

Requesting Refund ☐Yes ☐No

PERMISSION FOR RELEASE OF MEDICAL INFORMATION:
I authorize my physician to release information necessary to give a statement concerning my medical condition for documenting this medical withdrawal.

_____
(signature)

PHYSICIAN'S STATEMENT:

An official physician's statement on letterhead stationery must be attached to this form stating patient's condition and dates of treatment and/or hospitalization with effective dates.

In my professional opinion the student petitioning for medical withdrawal from Peninsula College cannot complete the current quarter of school for the medical reasons I have stated.

_____
(Physician's signature)

VERIFICATION OF LAST DAY OF ATTENDANCE BY COLLEGE:

_____ _____
_____ _____
_____ _____

Medical withdrawal refund_____ **Approved**_____ **Disapproved**_____

School Official Signature_____

Revised 2/10/09

QTR_____

Name_____