Request for Medical Withdrawal

ESP@wayne.edu

Mail/Fax/Email to: Records and Registration Office
5057 Woodward, Fifth Floor
Detroit, MI 48202
Phone: (313) 577-3541
Fax: (313) 577-7870

Drop Off: Student Service Center Lobby
Welcome Center
42 W. Warren
Detroit, MI 48202
Phone: (313) 577-2100

A medical withdrawal is a complete withdrawal from all courses. For approved requests, the University Medical Withdrawal Policy will grant 100% tuition and fee cancellation if a student stops attending ALL classes before the end of the 10th week of the scheduled class meeting period in a full fall/winter term. Medical documentation will need to confirm that medical attention was provided during this time period. For medical withdrawals occurring during the 11th or 12th week, tuition cancellation will be granted at the rate of 60%. There is no tuition cancellation after the twelfth week of the term. These periods are adjusted proportionally for courses that do not run the full term. While a request is under review tuition payments should be made as scheduled.

Deadline Date for Filing: **Fall Term ~ March 1 Winter Term ~ July 1 Spring/Summer Term ~ November 1**
If the deadline falls on a weekend, it will be extended to the next business day.
Applications must be received by the filing deadline date because exceptions to the deadline will not be granted.

Instructions:

1) Submit a request to withdraw to your instructor(s) via Academica by using the "Withdraw from a Class" feature.
2) Complete Part I of this form then have your physician(s) complete Part II.

Part I. Must be completed by student:

Name (last, first, middle):	**WSU Access ID:**
WSU ID Number.:	**Phone Number:**

ALL DECISIONS ARE COMMUNICATED THROUGH YOUR WSU E-MAIL ADDRESS

Applicable Term/Year (complete one): Fall 20_____ Winter 20_____ Spring-Summer 20_____

Provide all requested data for your classes in the applicable term (per sample line):

Subject & Course Number	CRN	Credit Hours	Date Last Attended	Date of Drop-Add-Withdraw	Office Use
Sample: *ENG 1000*	*12345*	*3*	*10/31/2016*	*11/01/2016*	

Provide a complete statement of the facts and the resolution you are requesting. If necessary, attach additional pages with documentation.

Are you a financial aid recipient? (check one) ☐ Yes ☐ No
If yes and this request is approved, you may have to repay aid for the applicable academic year. For more information, Student Service Center staff are able to answer your questions at (313) 577-2100 or studentservice@wayne.edu

Certification and Release of Information – I hereby authorize any physician or hospital to release all information with respect to myself which may have a bearing on this request. I hereby certify the information provided above is correct and true to the best of my knowledge.

Student Signature: Date:

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Part II. Must be completed by Physician

If more than one physician is treating this condition, please provide a separate copy of this sheet to each

Patient's Name (last, first, middle):	**WSU ID no. or Access ID:**

A. Diagnosis (including any complications):

B. History:

1. Date patient first visited you for this condition (MM/DD/YYYY): _____/_____/_____
2. Did you prescribe that patient should stop attending classes? (circle one) **YES** **NO**
   a. If yes, date on which you advised patient to stop attending classes: _____/_____/_____
   b. If you had seen the patient earlier, would you have advised an earlier stop date? (circle one) **YES** **NO**
   c. If yes, date you would have advised to stop attending classes: _____/_____/_____
3. Date patient is released to return to classes: _____/_____/_____
4. Upon return to school, will patient have any restrictions? (circle one) **YES** **NO**
   If yes, describe:

C. Progress:

1. Circle progress made by patient: **Recovered** **Improved** **Unchanged** **Retrogressed**
   From _____/_____/_____ To _____/_____/_____

2. Did current condition result in a period of confinement? (circle one) **YES** **NO**
   If yes, where and when? House: From _____/_____/_____ To _____/_____/_____
   Hospital: From _____/_____/_____ To _____/_____/_____

3. Was surgery performed? (circle one) **YES** **NO**
   If yes, date: _____/_____/_____ Type: **Inpatient** **Outpatient**

D. Physical Therapy:

Did the current condition result in a period of physical therapy? (circle one) **YES** **NO**
If yes, Date of first visit: _____/_____/_____ Date of most recent visit: _____/_____/_____
Frequency (circle one) **Weekly** **Monthly** **Other (specify)**
If physical therapy is completed, date of final visit: _____/_____/_____

Physician's Signature: Date:

Physician's Name (Please print):

Practice Name and Street Address:

City, State, Zip/Postal Code:

Telephone Number: Fax Number: