

# CALIFORNIA STATE UNIVERSITY, LONG BEACH

## MEDICAL WITHDRAWAL PETITION STATEMENT OF SERIOUS ILLNESS OR INJURY

University Withdrawal Policy (Policy Statement 02.02) includes a provision for a student who becomes seriously ill or injured, or is hospitalized and hence unable to complete the academic term, to request a medical withdrawal. This medical withdrawal request is only good for one academic semester. If it is necessary for a student to be out more than one semester, the student may be eligible for an Educational Leave. For specific details, please refer to [www.csulb.edu/enrollment](http://www.csulb.edu/enrollment).

**DEADLINES: FOR SPECIFIC DEADLINE DATES REFER TO [www.csulb.edu/enrollment](http://www.csulb.edu/enrollment).**

*Note: the deadline to request a medical withdrawal and refund of registration fees is earlier than the deadline to request a medical withdrawal only.*

### PROCEDURE:

1. Complete and sign Part I
2. Ask your physician or licensed health care provider to complete and sign Part II (reverse side)
3. Submit the completed form to Enrollment Services, BH-101, but **no later than the end of the term of the requested withdrawal.**

### PART I - TO BE COMPLETED BY STUDENT (PLEASE PRINT)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Student Identification Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work or Cell \_\_\_\_\_

Enter Year of Requested Medical Withdrawal:

Fall 20 \_\_\_\_\_ Spring 20 \_\_\_\_\_ Summer Session 20 \_\_\_\_\_ I II III Winter 20 \_\_\_\_\_  
*circle appropriate session(s)*

### PLEASE READ CAREFULLY BEFORE SIGNING BELOW:

I understand that:

- Both sides of this form must be completed, in full, for the request to be accepted and considered
- Faxed or photocopied forms are not acceptable and will result in denial of my request
- I will receive 'W' (withdrawal) grades on my official record for all enrolled courses
- I am not entitled to a refund of applicable fees **if the complete request is received after the published refund deadlines**
- I may have to repay all or part of any financial aid award received if I have received a financial aid check or if financial aid has been applied to my account (check with Financial Aid before withdrawing)
- Approval of this request may affect visa status for international students (check with the Center for International Education, if applicable, before withdrawing)
- A request for medical withdrawal may not be appropriate if you are currently not enrolled for this semester. Refer to [www.csulb.edu/enrollment](http://www.csulb.edu/enrollment) for information regarding eligibility for an Educational Leave.
- Copies of this form may be provided to all appropriate campus offices
- Falsification of information may lead to disciplinary action by the University
- Instructors of the classes in which I am currently enrolled may be notified if this request is approved
- By signing this form, I authorize my health care provider to release necessary information to the University related to this request. Furthermore, I understand that my health care provider may be contacted for verification purposes.

**Student Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Enrollment Services Office

Grade Assignment:  WE Withdrawal for Extenuating Circumstances

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

**MEDICAL WITHDRAWAL PETITION  
STATEMENT OF SERIOUS ILLNESS OR INJURY**

**STUDENT NAME** \_\_\_\_\_

is requesting a medical withdrawal from all courses at California State University, Long Beach and has authorized you to release information (see reverse side of this form). A Statement of Disability must be completed by a physician or licensed health care provider and submitted to Enrollment Services before the requested medical withdrawal can be considered.

Permanent or temporary serious illness or injury is the *only* acceptable basis for a medical withdrawal. You may be contacted to verify information provided.

**PART II – TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER (PLEASE PRINT)**

**Name of Physician/Health Care Provider:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP Code:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**1) Describe the serious illness or injury that is preventing the student from completing the term:**

\_\_\_\_\_  
\_\_\_\_\_

**2) Why is this illness/injury preventing the student from completing the term?**

\_\_\_\_\_  
\_\_\_\_\_

**3) When did this illness/injury occur?**

\_\_\_\_\_  
\_\_\_\_\_

**4) Dates of examination for the condition claimed as the basis for medical withdrawal:**

\_\_\_\_\_  
\_\_\_\_\_

**5) When do you believe the student will be well enough to resume his/her academic program?**

\_\_\_\_\_  
\_\_\_\_\_

**6) What treatment is the student undergoing?**

\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**License #:** \_\_\_\_\_