



Student Request for Medical Withdrawal

Student's Full Name: _____ UNA L#: _____

Email Address: _____ Cell Phone: _____

Please check the box for the type of withdrawal you are requesting and indicate the term or semester(s). For example, Fall 2015, Summer I 2015, Spring 2016, etc. Incomplete forms will not be processed.

Medical Withdrawal (current term or semester): Submission and all documentation required by the end of business day of the last day of classes. Term or Semester Requested: _____	Retroactive Medical Withdrawal for previous term or semester: Submission of all documentation required for previous term or semester within 60 days (in extraordinary circumstance an extension may be granted by the Provost or President of the University) of the end of business of the last day of classes. If approved, the effective date of withdrawal will be the last day of classes for the semester/term in question. Term or Semester Requested: _____
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Describe how or why the condition(s) has/have interfered with your academic performance. _____

When did your medical-related concerns begin? Describe how these concerns evolved. _____

What was the last date you attended any of your classes and/or submitted assignments? _____

Did you provide any medical documentation to your teachers for the semester or term in question? _____

If yes, please attach to this form.

Describe what campus-based resources you utilized for the term or semester in question to assist you in support of academic success (i.e., Student Counseling Services, University Success Center, Disability Support Services, University Health Services, etc.). _____

*Licensed Provider Recommendation for Medical Withdrawal form must accompany this form.

With my signature below, I attest to the accuracy of the information given and:

- I understand that the University Case Manager, Disability Support Services and/or University Health Services may contact my healthcare provider(s) and other campus resources to collect additional information and/or to share information related to my request for a medical withdrawal or potential return to campus. I give full permission and consent to any such contact and information sharing/collection.
- I understand I am responsible for providing the Licensed Provider Recommendation for Medical Withdrawal form to the licensed medical provider who has treated me. I further understand that, if I am requesting a retroactive withdrawal and I am intending to enroll or register in an upcoming semester or term, I must also submit the required paperwork, Licensed Provider Recommendation for Return to Campus (Medical Clearance).

- I understand that it is my responsibility to confirm that the additional required documentation in support of this request is delivered to the University Case Manager according to the time requirements stated above.
- I certify that I did not take a final exam or complete a course(s) where no final exam was required for the semester in question and further understand having done so makes me ineligible for medical withdrawal.
- I acknowledge that, if I have questions regarding the financial implications of withdrawal, I will contact Student Financial Services at 256-765-4278 prior to my submission of this paperwork.
- I understand that if my medical withdrawal request is approved and processed, I may owe a balance to the University. Furthermore, I understand that if I fail to pay any unpaid balance on my student account, I will be personally responsible for, and agree to pay, all costs and fees of collection, including late payment fees, transcript hold fees, interest, collection fees of third-party collection and/or any other charges necessary for the collection of this debt.
- I understand that if I am registered for a future/upcoming term and I fail to provide appropriate medical documentation as specified in the University's Medical Withdrawal Policy clearing me to return to UNA, my future class schedule will be cancelled approximately a week prior to the beginning of the semester.

Signature: _____ Date: _____