CAMPUS HEALTH

Medical Withdrawal Healthcare Provider Verification

STUDENT INFORMATION

Name: _____
Last *First* *M.I.* *Student I.D. (8 digit)*

Arizona email: _____ Phone: _____

Term(s) affected (ex. Fall 2023):

_____

HEALTHCARE PROVIDER USE ONLY

I, _____ (print name and credentials) verify that I am a licensed healthcare professional and the above-named student is (or was) under my professional care for a health condition that impacted their ability to participate and perform as expected in their education.

Date of onset of the health-related circumstances that led to the request for withdrawal:

_____ ***REQUIRED**

The following impact applies to this student for the terms identified above (please check one):

☐ This condition prevented the student from successfully attending and completing some of their coursework in the affected term(s)
☐ This condition prevented the student from successfully attending and completing all the coursework in the affected term(s)

☐ Other. You can provide comments below if the above options are not relevant. Please do not disclose personal health information of the patient.

_____ _____
Healthcare provider signature Date

_____
State and license number

_____ _____
Address Office phone

_____
City, State, ZIP code

Last updated: 5/2024