MEDICAL WITHDRAWAL DOCUMENTATION FORM

Please complete the top portion of this form then forward to your treatment provider.

Student Name:_____ Today's Date:_____

Date of last class attendance:_____ Student ID#_____

I understand that a medical withdrawal requires review of my pertinent medical information by the appropriate treatment provider. I hereby agree to authorize release of this information.

Signature_____

The portion below is to be completed by your treatment provider.

The above named student has applied for a medical withdrawal from Elizabethtown College. He/she has designated you/your office as a source of pertinent medical information to support his/her request. Please complete and return or fax to the Director of Student Wellness at (717) 361-4776.

Name and title of treatment provider:_____

Address:_____

Phone:_____ Fax:_____

Dates student was under the care of a qualified health professional (e.g. physician, psychiatrist, psychologist):

Diagnosis and general nature of the medical condition:

Describe how this medical condition impairs the student's ability to complete his/her coursework:

_____ _____

Provider Signature Date