CALIFORNIA STATE UNIVERSITY FULLERTON

Petition for Medical Withdrawal | Medical/Mental Health Professional Form

Please return this form, completed by a licensed Physician/Mental Health Professional, directly to the student for submission. This form is not required to submit a request for Medical/Mental Health Withdrawal but may be submitted for the purposes of providing appropriate medical documentation in lieu of a letter from the licensed Medical/Mental Health Professional.

STUDENT TO COMPLETE

I authorize my physician/mental health professional to release the information requested for my withdrawal from a course or courses at California State University Fullerton for the semester/term mentioned below. I understand that the information will be handled in a confidential manner and in compliance with HIPAA.

Patient/Student Name:

CWID#

Date of Birth:

Student Signature:

Date:

PHYSICIAN / MENTAL HEALTH PROFESSIONAL TO COMPLETE

Date of onset of condition:

Diagnosis/Symptoms:

Date(s) under your care for this specific diagnosis:

Date(s) of hospitalization, *if applicable*:

Effect(s) the condition has on the student's ability to perform in an academic setting:

CERTIFICATION

I certify that the patient mentioned above is under my care and due to the symptoms associated with the diagnosis/condition, they are unable to function in an academic setting and recommend they withdrawal from the semester and classes mentioned below.

Semester/Term

Class / Classes

Name of Medical/Mental Health Professional

License ID #

Address:

Phone:

Signature - Medical/Mental Health Professional:

Date:

Name of Supervising Professional (*if applicable*):

License ID #

Signature - Supervising Professional *(if applicable)*: