Date

Name of Organization

Street Address

City, State Zip Code

Telephone number

First and Last Name of student

Students Address

City, State and Zip Code

MEDICAL WITHDRAWAL

First and Last Name (Date of Birth, Student ID# 8 numbers) has a medical condition which prevented him/her from performing academically at the level he/she would otherwise be capable of and requires continued treatment. It is my recommendation that he/she **medically withdraw** from the (Fall or Spring + Year) semester.

**OR**

First and Last Name (Date of Birth, Student ID# 8 numbers) has a medical condition which prevented him/her from performing academically at the level he/she would otherwise be capable of and requires continued treatment. It is my recommendation that he/she enroll only **part time**for the remainder of (Fall or Spring + Year) semester.

Sincerely,

Name of licensed medical doctor, psychiatrist, doctor of osteopathy, licensed psychologist, and clinical psychologist. **\*Signature must have one of the following to be valid/accepted**

Insert full credentials