TEXAS SOUTHERN UNIVERSITY

STUDENT REQUEST FOR MEDICAL WITHDRAWAL

This is a request to certify a serious health condition that may prohibit a student from continuing his/her education. The student is required to have the form completed by healthcare provider who is treating the student for a specific condition. Section I of this request is to be completed by the student. Section II is to be completed by the treating healthcare provider. Healthcare Providers include: MD, DO, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Psychologist.

Section I – (To be completed by the student)

Student's name: _____

Student's T-number: _____ / Birthdate_____

Student's address and Phone number: _____

Student's Email Address: _____

Major:

☐Freshman☐Sophomore☐Junior ☐Senior☐Graduate/Professional☐Law

Last date of attendance (for each enrolled class): _____

Section II – Please Check "Yes" or "No" for Questions A through D

A: Are you registered with the Office of Disability Services? □ Yes □ No

B: Do you reside in campus housing? □ Yes □ No

If yes, talk to the Office of Housing before completing this application. They will explain the financial impact of a semester withdrawal on your housing bill.

C: Are you receiving financial aid (to include scholarships or military benefits)? □ Yes □ No

If yes, go to the Office of Financial Aid before completing this application. Request information on how this request could affect your financial aid. Your financial aid counselor must sign and date this application here.

Financial Aid Signature:

Date: _____

D: Have you applied for a medical withdrawal in the past? □ Yes □ No If yes, please list date(s):

_____

E: Veterans: If you receive ANY veteran education benefits, you must be seen by the Veteran Affairs office for information on how this request could impact your benefits.

Veteran Affairs Signature:
Date: _____

Section III – Required Signatures

You are required to speak with your academic advisor to discuss the academic consequences of a medical withdrawal.

College/School:

Advisor/Chair/Dean Printed Name: Extension:

Signature: Date:

International students:

Go to the International Students Office to receive information about how this request could affect your visa status.

International Advisor Signature: Date:

Section IV: Student Acknowledgement

I acknowledge that the Medical Withdrawal Request must be submitted within the same semester and no later than ninety (90) days after the end of the semester in question _____ (initial)

I acknowledge that I must upload the Medical Withdrawal Healthcare Consent Form to Medicate at https://tsu.medicatconnect.com within five (5) business days after submitting the Medical Withdrawal Request. _____(initial)

I acknowledge that if my request is denied, I understand that I am able to appeal to the committee only if there is additional information or documentation that can be provided. I must appeal no later than ten (10) days after receiving the decision. _____ (initial)

I acknowledge that if my request is approved, I will be withdrawn from all classes and will receive a 'W' for each class, that will not count towards the six-withdrawal rule. _____(initial)