

**Student / Patient Information**

**Name:** \_\_\_\_\_ **Student ID #:** \_\_\_\_\_  
 (Last) (First) (Middle)

**Address:** \_\_\_\_\_  
 (Street) (City, State) (Zip)

**Telephone:** \_\_\_\_\_

**Date Medical Condition Began:** \_\_\_\_\_

**Semester:**       Fall 20\_\_\_\_     Winter 20\_\_\_\_     Spring 20\_\_\_\_     Summer 20\_\_\_\_

**Message to Health Care Provider**

Your patient is asking to be considered for special withdrawal and/or refund privileges that are limited to cases of serious medical conditions. To be eligible, the student must be under the care of a qualified health care provider and unable to meet academic responsibilities for at least three weeks during a fall or winter semester. For a spring or summer special withdrawal, incapacity for at least 1/5 of the duration of the session must be demonstrated. If your patient's condition during the semester period shown above meets these criteria, please enter the medical facts that support your determination below.

**Health Care Provider Information & Consent**

Description of the facts that support the patient's inability to meet academic responsibilities:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I, \_\_\_\_\_, verify that during the above semester period, this patient was ill and unable to meet academic responsibilities. I am aware that a follow-up phone call will be made from the Registrar's Office to verify the authenticity of this document.

**Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Provider's Name:** \_\_\_\_\_ **License Number:** \_\_\_\_\_

**Medical Office:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
 (Street) (City, State) (Zip)

**Telephone:** \_\_\_\_\_

**Please return completed form to the patient or SVSU's Registrar's Office**  
**Office of the Registrar, 7400 Bay Road, University Center, MI 48710**  
**registrar@svsu.edu - Phone (989) 964-4085 - Fax (989) 964-2555**