Medical/Compassionate Withdrawal General Information

PLEASE READ CAREFULLY

A medical withdrawal may be requested when extraordinary circumstances, such as a serious illness or injury, prevent the student from continuing classes. This policy covers both physical-health and mental-health difficulties.

A compassionate withdrawal may be made in extraordinary cases in which a significant personal situation, (for example, the serious illness of a child or spouse or the death of a parent, child or spouse) prevents a student from continuing in classes.

Medical/compassionate withdrawals may be considered when incompletes or other arrangements with instructors are not available, or when restricted withdrawals and other enrollment options are not possible.

All requests require thorough and credible documentation. Usually, consideration is for a complete withdrawal; application for less than a complete withdrawal must be especially documented to justify the selective nature of the request. It is your responsibility to insure appropriate forms and documents are included and complete. However, completing the process does not guarantee or ensure approval; each case is reviewed individually. The medical designee may seek additional information from you, from your instructors or from those providing the documentation. Verification of authenticity of documentation is standard practice.

If you are receiving financial assistance, you are strongly encouraged to consult with a Student Financial Assistance Counselor to identify and understand the financial assistance/monetary implications of processing this withdrawal transaction.

The following items are required for consideration of this request:

- Completed cover sheet, including your signature
- Completed medical/compassionate withdrawal request form
- Appropriate documentation as indicated on coversheet.

Incomplete requests will significantly delay the reviewing process.

Submission of packet

Please submit the packet of information either in person or by mail to the attention of the Withdrawal Designee Tim Weiss.

Tim Weiss
Undergraduate Student Academic Services Office
502 East Monroe Street, Suite C250, Mail Code 8220
Phoenix, AZ 85004-4431

Updated: 7/17/2014
Please submit this over sheet with the required documentation, a completed medical/compassionate withdrawal form, and a brief statement outlining the reason for your request. 
*Incomplete requests will significantly delay reviewing process.*

**Name**

**Affiliate ID**

Indicate type of request.  
___ Medical Withdrawal  
___ Compassionate Withdrawal

1. **Request for Documented Medical/Compassionate Withdrawal form**
   
The top of the form must be completed and signed by you. If you are physically unable to do so, a parent, spouse or other representative may do. Please make sure to fill in the last date attended box on the request form. Write a brief statement outlining the reason for your request. The medical designee reviewing the request may seek additional information.

   ___ Form completed and signed  
   ___ Brief Statement attached

2. **Documentation**

   **Medical Withdrawal**
   
   A letter, on letterhead, from your health care provider must be submitted in a sealed envelope or mailed directly to the medical designee. The letter must include the following information:
   
   - Date of the onset of the illness
   - Dates of medical care
   - General nature of your medical condition and how/why it prevented completion of your coursework
   - Date of your anticipated return to school
   - Last date you were able to attend class

   **Check one:**
   
   ___ Sealed letter included  
   ___ Letter being sent to address on previous page

   **OR**

   **Compassionate Withdrawal**
   
   **Check one:**
   
   ___ Documentation being gathered to support request  
   ___ Documentation included to support request. Please list.  
   
   ____________________________________________________________  
   ____________________________________________________________  
   __________________________

   I have read the information sheet regarding this request and understand that completing the request does not insure approval. All the information I am providing is accurate and truthful to the best of my knowledge.

   __________________________
   Signature  
   __________________________
   Date

Updated: 3/26/2014
**REQUEST FOR DOCUMENTED MEDICAL/COMPASSIONATE WITHDRAWAL**

**ARIZONA STATE UNIVERSITY**
**UNIVERSITY REGISTRAR’S OFFICE**

**Medical or Compassionate Withdrawal (Check One):**

- [ ] Medical Withdrawal: This form must be accompanied by an original letter from your health care provider, documenting the date of onset of illness, dates of medical care, general nature of your medical condition, why/how it prevented completion of your course work, date of your anticipated return to school, and the last date you were able to attend class. The original letter must be typed on your health care provider’s letterhead stationery and submitted in a sealed envelope.

- [ ] Compassionate Withdrawal: This form must be accompanied by credible documentation appropriate to your situation. Contact your college designee to determine what documentation will be acceptable for your specific situation.

**NAME (Last, First, ML.)**

**ASU I.D. NUMBER**

**PHONE NUMBER:**

**PERMANENT ADDRESS (NUMBER, STREET, APT.)**

**CITY, STATE, ZIP**

Are you receiving or did you receive Financial Aid or a scholarship? [ ] No  [ ] Yes*

*Please note that Financial Aid recipients who completely withdraw from the university may be responsible for repayment of funds.

**INTERNATIONAL STUDENT OFFICE ADVISING SIGNATURE:**

Date:

**SEMMETER (Check One):**  [ ] Spring  [ ] Summer  [ ] Fall

**YEAR:**

**TYPE OF WITHDRAWAL**

- [ ] Course Withdrawal (Withdrawal from classes listed below).
- [ ] Complete Withdrawal (Withdrawal from all classes. List all classes below).

<table>
<thead>
<tr>
<th>Schedule Line Number: (i.e. 12345)</th>
<th>Semester Hours: (i.e. 0, 1, 2, or 4)</th>
<th>Course Prefix &amp; Number: (i.e. ENG101)</th>
<th>Session: (i.e. A, B, or C)</th>
<th>Last Day Attended: (i.e. 1/1/2011)</th>
<th>Approved Effective Date (College Use Only)</th>
</tr>
</thead>
</table>

I request medical/compassionate withdrawal as indicated above and supported by the attached documentation. Permission is granted to contact any of the documentation/information providers. I confirm that information provided is accurate and complete, and I understand that falsification may result in disciplinary action up to and including suspension or expulsion from the university. An approved medical/compassionate withdrawal cannot be reversed. Financial Aid recipients who completely withdraw from the university may be responsible for repayment of funds.

**Student Signature** (I acknowledge that I understand the above statement):

Relationship (If not student):

Date:

**Medical/Compassionate Withdrawal College/Academic Unit Authorized Signator:**

APPROVAL (Check One):  [ ] Approved  [ ] Disapproved

- [ ] Change probation status to (Check One):  [ ] P  [ ] C  [ ] Good Standing  [ ] No Change
- [ ] Should the Student be put on administrative hold?  [ ] Yes  [ ] No
- [ ] Remove from future classes for indicated term(s):  [ ] Spring  [ ] Summer  [ ] Fall

Year:

Comments:

**DISTRIBUTION:**

All documentation submitted with this form is retained by the designee and is not copied or forwarded to any other office or department.

If request is disapproved: All copies and documentation are retained by College/Academic Unit for five years.

If request is approved:

- Original: Retained for five years by Designee with originals of medical documentation
- Copy: University Registrar, Records & Enrollment Services
- Copy: Student Accounts, Student Financial Assistance, Student

**College/Academic Unit:**

**Mail Code:**

**Department:**

**Phone:**

**Received Stamp**

**For Registrar’s Office Use Only**

**Processed Stamp**

**Official Withdrawal Date:**

**Notation (If Needed):**

Rev. 2/8/2012