

**Henry Wise Wellness Center**

Christa McAuliffe Residence Hall, Lower Level

14000 Jericho Park Rd, Bowie, MD 20715

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**Medical Withdrawal Form**

Medical withdrawals are reserved for students with an extenuating medical circumstance making it difficult for the student to continue the coursework.

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| --- |
| Student name (print): Semester/Year of withdrawal: |
| Date of birth: BSU ID: |
| Phone number: Email: |
| *By signing below, I give Bowie State University Medical Withdrawal Review Committee permission to contact my licensed healthcare provider listed here to verify the accuracy and truthfulness of information included in this form. I understand that the University reserves the right to update medical withdrawal policies and protocols.*  **Student signature:**  Date: |
| **The sessions listed below must be fully completed and signed by your U.S. licensed healthcare provider. Any incomplete, illegible, or missing information will result in delays in processing your medical withdrawal application. To ensure proper evaluation, please attach all relevant medical documentation corresponding to the requested semester.** |
| Diagnosis:  Date of onset:  Treatment/visit dates: |
| Effects of medical condition on the student’s ability to perform: |
| Prognosis:  Timeframe of recovery: |
| *By signing below, I acknowledge that the student is under my care for the above diagnosis and that* ***I am supporting a medical withdrawal*** *for the student’s wellbeing. The information I have given above is true and accurate.* |
| Licensed health care provider’s name (print legibly):  Signature:  Date:  NPI number:  Office name and address:  Phone number: Email: |
| For Office use: This form has been reviewed and verified by the BSU Medical Withdrawal Review Committee.  Name:  Signature: Date: |

**Please submit the completed form to the Henry Wise Wellness Center through the patient portal (preferred), by fax, mail, or in person.**