SAGINAW VALLEY STATE UNIVERSITY

Health Care Provider
Medical Withdrawal Verification Form

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