



University College
Withdrawal for Extenuating Circumstances Medical Documentation Request

Instructions:

Your patient is a student at the University of North Carolina Wilmington who is applying for an Extenuating Circumstance Withdrawal, due to serious medical circumstances beyond their control. Please note, in exceptional cases it is allowable for your patient's guardian to initiate/complete the withdrawal process.

Please note: The University College at University of North Carolina Wilmington routinely contacts medical providers to authenticate information provided in withdrawal documentation.

A qualifying Extenuating Circumstance is only for a medical emergency that resulted in the patient being advised not to attend school for an extended amount of time. For the student to receive clearance to return to the university, documentation will need to be provided of treatment received and suitability to return.

Please fax this completed form and any additional documentation to the University College at (910) 962-4290 or by email to ucappeals@uncw.edu. For assistance, contact the University College at (910) 962-3245.

Student Information:

Name (Last, First, MI):

Date of Birth:

[Text input box for Name]

[Text input box for Date of Birth]

Is the student a patient of yours?

Radio buttons for Yes and No

Health Care Provider Information:

Date of Initial Appointment:

Date of Initial Diagnosis:

[Text input box for Date of Initial Appointment]

[Text input box for Date of Initial Diagnosis]

Dates of follow-up appointments:

[Text input box for Dates of follow-up appointments]

What was the diagnosis and what impact did it have on his / her ability to carry out their academic responsibilities? For pre-existing conditions, please describe the changes that occurred within the term (Fall, Spring, or Summer Semester) which prevented attendance of classes.

[Large text area for diagnosis and impact description]



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Was the patient admitted into the hospital? Yes No If yes, give dates: []

Was the patient advised not to work? Yes No If yes, give dates: []

Was the patient advised not to attend school? Yes No If yes, give dates: []

Was the patient following recommended course of treatment(s)? Yes No If yes, give dates: []

What was the recommended course of treatment? Please explain if the patient did not follow recommended course of treatment(s):

[Large empty text box for treatment details]

Signature and Agreement:

By signing below, I attest that the patient received the care documented above, and it is my professional opinion that the student was not able to attend and / or participate in classes during the duration noted previously. I also understand that I might be contacted to provide more detailed information.

Signature: []

Date: []

Name: []

Title: []

Organization: []

Phone Number: []

Questions? For further assistance with this form, contact the University College at (910) 962-3245