SUNY ORANGE

Wellness Center
115 South St
Middletown, NY 10940

Request a
Medical Withdrawal

Name of Student	Student ID#:	Date:
Address:		

SEMESTER/YEAR: FALL_____ SPRING_____ SUMMER _____

Official Withdrawal from a Course(s) because of a Medical Condition/ Mental Health Condition

When students must withdraw from the College or course(s) due to their personal medical condition, they must obtain written verification from the physician/ mental health professional and include all other required withdrawal forms. All such information given to the College is treated as confidential and privileged, as allowable by law. The student's request for a medical withdrawal should be submitted to WellnessCenter@sunyorange.edu before the end of the semester in which the condition occurs. The Director of the Wellness Center will make a decision on the request for a medical withdrawal and inform the Registrar of decision. The student has the right to appeal this decision to the VPAA using the academic grievance procedure.

Note that withdrawals approved for medical reasons do not generate an automatic refund of tuition, waiver of the physical education requirement, or waiver of financial aid requirements. If approved for a medical withdrawal, the student must still fill out a Tuition Credit Application.

	Course(s) to be Medically withdrawn from				
CRN	Course Subject	Course Number	Course Title	Section	Credits

This form must be accompanied by an original documentation from your health care provider/Mental Health Professional. It is recommended that you provide your healthcare/mental health provider with this checklist to assure that he/she writes an adequate letter in support of your request. **Your request will not be reviewed unless all the information requested below has been provided.** Date of onset of illness? Dates of medical care? General nature of medical condition/diagnosis? Why/how it prevented the completion of coursework? Last date you were able to attend class?

The original documentation must be provided on your health care provider's letterhead stationery including Physician's name, mailing address, Medical License Number.

We encourage you to use your SUNY Orange email account as it is encrypted, if you choose to send confidential information via your personal email, we cannot guarantee the information is protected. Please submit all documentation to WellnessCenter@sunyorange.edu.

Students Signature	Date

OFFICE USE ONLY**

_____ _____WC
Approved Date **Initials**

_____ _____WC
Denied Date **Initials**

_____ _____REG
Process Date **Initials**