Cal State Fullerton

STUDENT TO COMPLETE

I authorize my treating medical and/or mental health provider to release the information necessary to support my request for a **Retroactive Medical/Mental Withdrawal** for the semester noted below at California State University, Fullerton. I understand that this information will be managed confidentially and in accordance with HIPAA regulations. I also acknowledge that certain information may be shared with appropriate campus departments or local law enforcement agencies, as required by applicable state and federal laws or CSU system-wide policies.

Student Name: **DOB:** **CWID:**

Student Signature: **Date:**

MEDICAL/MENTAL HEALTH PROFESSIONAL TO COMPLETE

To the Treating Medical/Mental Health Professional:

Please complete and return this form directly to the student for submission. While this form is not required to initiate a request for a **Retroactive Medical/Mental Health Withdrawal**, it may be submitted in place of a formal letter to provide appropriate medical documentation in support of the request.

Date of onset of condition: **Date(s) of hospitalization, if applicable:**

Date(s) under your care for this specific diagnosis:

Diagnosis/Symptoms:

Effect(s) the condition has on the student's ability to perform successfully in an academic setting:

Semester/Term Year

Class/Classes (must be listed for partial withdrawal requests)

CERTIFICATION: I hereby certify that the patient named above was under my care during the semester referenced above. Based on my medical assessment, the symptoms associated with their diagnosis/condition during that period significantly impaired their ability to function in an academic setting. Therefore, I recommend that they be granted a Retroactive Medical/Mental Health Withdrawal from the specified semester and associated classes.

Name of Medical/Mental Health Provider:

Medical/Mental Health License#

Signature of Medical/Mental Health Provider:

Date:

Facility Address:

Facility Phone Number:

Signature of supervising professional (if applicable)

Facility Stamp:

License #