

Medical Withdrawal Instructions

A medical withdrawal does not mean a student will receive a refund of tuition. Students may be responsible for some or all tuition liability.

Please note: The Health Center reviews requests for medical withdrawals for the current or prior semester for WU grades only. Requests for all other semesters may be brought to 1A-101 for submission to the Committee on Course and Standing.

1. Complete the Request for Medical Withdrawal form and submit it to the **Health Center (1C-112)**. Please call 718-982-3045 to make an appointment. If you are unable to submit the Request for Medical Withdrawal in person, you must provide written authorization giving another individual permission to submit the form on your behalf along with a copy of your student ID card.
2. Your medical or mental health provider must complete, sign, stamp and date the Request for Medical Withdrawal form.
3. After review of the Request for Medical Withdrawal form by a Health Center professional staff person, you will receive a Medical Withdrawal Confirmation form. You will need to visit both the **Financial Aid Office (2A-401)** and the **Bursar's Office (2A-105)** to determine the financial impact of withdrawing.
4. Bring your signed Medical Withdrawal Confirmation form to the **Office of the Registrar (2A-107)** to complete the medical withdrawal request process.
5. The medical withdrawal request will be processed within 14 calendar days. To check the status of this request, review your CUNYfirst Self-Service page. If you have additional questions about the status of your request, you can follow up with the Registrar's Office – 718-982-2120.

Thank you for your cooperation.

Request for Medical Withdrawal

Student Name: _____ Phone #: _____

Address: _____

Date of Birth: _____ Empl ID#: _____

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Consent to Release or Discuss Health Information:

I hereby authorize my health care provider to release or discuss records and information regarding my physical or mental health to Health Center personnel for evaluation of my request for a medical withdrawal.

Student Signature: _____

Please have your Medical/Mental Health provider complete the information below and return the completed Request for Medical Withdrawal form to:
Health Center, 1C-112, 718-982-3045, Fax: 718-982-2966

To be completed by Medical/Mental Health Professional

Diagnosis: _____

Dates unable to attend classes for this particular diagnosis/illness. ***Dates must be within the semester (current or prior) from which the student is seeking a medical withdrawal.***

Hospitalization date(s), if applicable: _____

I recommend that the student: (select one): () withdraw from all classes
() reduce workload/classes

Reason that student needs to withdraw from all classes or reduce workload/classes:

Provider Name: _____ License ID#: _____

Signature: _____ Stamp: _____

Address: _____ Phone: _____ Date: _____