Medical Withdrawal Instructions

Please note:
The Health Center only reviews medical withdrawals for the current or prior semester. All other semesters are processed at the Counseling Center.

1. Obtain a Request for Medical Withdrawal form. This form is available at the Health Center (1C-112) or on the CSI Health and Wellness Services website.

2. Your medical or mental health provider must complete, sign, stamp and date the form before submitting it to the Health Center. Incomplete forms will not be accepted.

3. Call 718-982-3045 to schedule an appointment. Appointments are required.

4. Upon receipt, the nurse will review the Request for Medical Withdrawal form and refer you to the Registrar (2A-107). The Registrar will make the final decision regarding approval of the medical withdrawal.

5. If a student is unable to submit the Request for Medical Withdrawal in person, the student must provide written authorization giving another individual permission to submit the form on their behalf.

6. To check the status of the medical withdrawal request follow up with the Registrar’s Office one to two weeks after submission of the form.

If you have further questions, please call the Health Center at 718.982.3045.

Thank you for your cooperation.
Request for Medical Withdrawal

Student Name: _______________________________ Phone #: _______________________________

Address: ____________________________________________________________

Date of Birth: _______________________________ Empl ID#: _______________________________

Student Signature: _______________________________________________________

Please have your Medical/Mental Health Provider complete the information below and return the completed Medical/Mental Health Professional Certification to:

Health Center, 1C-112, 718.982.3045, Fax: 718.982.2966

Medical/Mental Health Professional Certification
To be completed by Medical/Mental Health Professional

Diagnosis/History of Illness: ____________________________________________________________

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: _________________________________________________

It is recommended that the student: □ 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: ___________________________________________