

If you need to withdraw from all your classes due to **extenuating circumstances\***, please see an advisor/program coordinator in your School/College. The advisor/program coordinator will discuss your options and assist you with the completion and submission of this petition if appropriate. Office of the University Registrar will review this petition upon receipt of all the necessary and supporting documentation.

Be advised that reducing your credit load can affect your eligibility for financial aid, loan deferment, insurance, progress towards your degree, student-athlete-eligibility, and visa status for international students. There may be additional restrictions. *In some cases, excused withdrawal may not result in tuition credits. Excused withdrawal may result in additional financial obligations, such as return of aid.*

**Student information**

Name: \_\_\_\_\_ TUID: \_\_\_\_\_

Phone#: \_\_\_\_\_ Email: \_\_\_\_\_

**Seeking excused withdrawal from:**

Fall    Spring    Summer I    Summer II    Year: \_\_\_\_\_

**\* CHECK EXTENUATING CIRCUMSTANCES**

**1. Serious medical circumstances that render student unable to return to class(es).**

Required pages: Petition for Excused Withdrawal (form), Student’s Personal Statement (form)  
Other information: Educational Record Release, Medical Provider’s Statement (1 form per provider)

**2. Serious family emergency that renders a student unable to return to all classes.**

Required pages: Petition for Excused Withdrawal (form), Student’s Personal Statement (form)  
Other information: Documentation to support personal statement

**3. Military deployment to a location that would render the student unable to return to class.**

Required pages: Petition for Excused Withdrawal (form)  
Other information: Deployment orders

**4. If you would like the committee to consider other extenuating circumstances.**

Required pages: Petition for Excused Withdrawal (form), Student’s Personal Statement (form)  
Other information: Documentation to support personal statement

**Advisor Name:** \_\_\_\_\_

**Advisor email:** \_\_\_\_\_

**Last date of attendance:** \_\_\_\_\_ **Date contacted by the student:** \_\_\_\_\_

**Advisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SUBMISSION INSTRUCTIONS:** Completed petition documents should be uploaded by advisor/program coordinator for review by the Office of the University Registrar through **Student360** by selecting EXCUSED WITHDRAWAL PETITION document type. Please combine petition pages and all supporting documents into a single PDF document (not portfolio) before uploading. Office of University Registrar will contact faculty to confirm attendance/participation dates.

This document must be submitted with the Petition for Excused Withdrawal form.

**Student information**

Name: \_\_\_\_\_ TUID: \_\_\_\_\_

**Seeking excused withdrawal from:**

Fall   Spring   Summer I   Summer II   Year: \_\_\_\_\_

1. Did you drop/withdraw from the course(s) during the add/drop or withdrawal period for the term? If not, why?

2. Did you immediately contact your advisor/program coordinator regarding your extenuating circumstance? If not, why?

3. What other offices did you contact regarding your extenuating circumstance?

4. Please explain the details of the extenuating circumstance. Attach additional pages if necessary.

## Consent for Release of Educational Records and Waiver

This document must be included with the petition for excused withdrawal.

I, \_\_\_\_\_, intending to be legally bound, authorize the release of educational records or information from educational records relating to me and maintained by Temple University to (please list any and all medical providers related to this case):

**1) Name of medical provider:** \_\_\_\_\_

**Practitioner type:**  Medical doctor     Psychiatrist     Psychologist     Other

**Address:** \_\_\_\_\_

**2) Name of medical provider:** \_\_\_\_\_

**Practitioner type:**  Medical doctor     Psychiatrist     Psychologist     Other

**Address:** \_\_\_\_\_

**3) Name of medical provider:** \_\_\_\_\_

**Practitioner type:**  Medical doctor     Psychiatrist     Psychologist     Other

**Address:** \_\_\_\_\_

**4) Name of medical provider:** \_\_\_\_\_

**Practitioner type:**  Medical doctor     Psychiatrist     Psychologist     Other

**Address:** \_\_\_\_\_

For the purpose of evaluating the petition for excused withdrawal from courses for a medical reason, I make this release and waiver understanding my right to prevent disclosure of information from my educational records under the United States Family Educational Rights and Privacy Act of 1974 (FERPA).

**Student signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

TUId: \_\_\_\_\_

Your patient is a student at Temple University and is seeking an excused withdrawal from classes based on a medical condition. This form is to be filled out by the medical doctor, psychiatrist, psychologist, or other licensed medical practitioner who is treating the student for the condition necessitating an excused withdrawal from classes. This form must be returned to the student to accompany his/her Petition for Excused Withdrawal. Thank you for your assistance.

**Student Name:** \_\_\_\_\_ **TUID:** \_\_\_\_\_ **Withdrawal Term:** \_\_\_\_\_

1) Did **you** provide medical treatment for the student named above? [YES] [NO]

2) Nature of the medical condition: \_\_\_\_\_

Is this a chronic condition? [ ] YES [ ] NO

3) Date treatment started: \_\_\_\_\_ Date treatment concluded (if applicable): \_\_\_\_\_

4) Given the medical diagnosis, do you believe the medical condition affected the student’s ability in the following area. **Note:** Not all required to be eligible for an excused withdrawal. If you are unsure, please use ‘H’ to explain.

- A. Attend class where the course was taught face-to-face [ ] YES [ ] NO [ ] UNSURE
- B. Attend class where the course was taught online [ ] YES [ ] NO [ ] UNSURE
- C. Actively participate in class: Work in groups [ ] YES [ ] NO [ ] UNSURE
- D. Actively participate in class: Work individually [ ] YES [ ] NO [ ] UNSURE
- E. Actively participate in class: Respond to questions [ ] YES [ ] NO [ ] UNSURE
- F. Participate in related activities such as Lab, Internship, etc. [ ] YES [ ] NO [ ] UNSURE
- G. Minor travel for class /academic activity [ ] YES [ ] NO [ ] UNSURE

H. Other- Please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) The treatment requires/required prolonged absence (e.g., hospitalization, recovery, etc.) from the University:

[YES] [NO] If yes, how long? \_\_\_\_\_

**Your role in the treatment of this student/patient:**

[ ] Medical doctor [ ] Psychiatrist [ ] Psychologist [ ] Other \_\_\_\_\_

Print your full name clearly: \_\_\_\_\_ Phone: \_\_\_\_\_

License number: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Today’s date: \_\_\_\_\_

**PLEASE DO NOT SUBMIT MEDICAL DOCUMENTS WITH THIS FORM**