

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

Complete petition documents should be submitted by advisor/program coordinator to the Office of the University Registrar via **TUsafesend** (<https://tusafesend.temple.edu>) to **registration\_our@temple.edu**. Please format filename of document as **TUID\_WE.pdf** (example: *91234567\_WE.pdf*).

**Case#:** \_\_\_\_\_

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?

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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**