



Petition for Withdrawal with Approved Excuse (WE)

(Use for both "Non-Medical" and "Medical" WE Petitions)

If you need to withdraw from all your classes due to extenuating circumstances*, please see an advisor in your School/College Advising Office. The advisor will assist you with the completion and submission of the *Withdrawal with Approved Excuse (WE)* petition. A university committee will review the petition upon receipt of all the necessary documentation. Follow the "Instructions for Filing a Withdrawal with Approved Excuse on page 5 of this document. Remember, you can drop courses with no record or financial obligation until the end of second week of the term. In addition, up until the end of the ninth week of term, you can take a regular withdrawal (W) from individual courses. Another option may be an Incomplete(s) (I). Please talk to your instructor(s) to discuss whether or not an Incomplete(s) is appropriate.

In any event, when considering any kind of withdrawal, be advised that reducing your credit load can affect your eligibility for financial aid, loan deferment, any insurance, progress towards your degree, for practice and competition for student-athletes, and for international students, student visa status. There may be additional restrictions.

Please consult your academic advisor, instructor(s), Student Financial Services, and for international students, International Student and Scholar Services before withdrawing.

Please complete:

Date _____

Name _____ TUID _____

Signature _____

Phone _____ Email _____

Semester/Year in which you are seeking the Withdrawal with Approved Excuse: _____

Extenuating Circumstance (See list below): Check 1 2 3 4

Last Date of Attendance in classes: _____

*APPROVED EXTENUATING CIRCUMSTANCES	
1.	Serious medical circumstances that render student unable to return to class(es). Under unusual circumstances, where the medical problem is directly related to or attributed to a single course, a 'WE' can be approved for that individual course. (Complete pages 1, 2, and 3 and page 4 upon return to the University.)
2.	Serious family emergency that renders a student unable to return to all classes. (Complete page 1 and provide applicable documentation.)
3.	Military deployment to a location that would render the student unable to return to class. (Complete page 1 and provide copy of orders.)
4.	If you would like the committee to consider other extenuating circumstances, complete page 1 and provide a description and supporting documentation.

<p>OFFICIAL USE ONLY:</p> <p>Petition Approved (circle): Yes No</p> <p>Notify Advisor (date): _____</p> <p>Last Day of Attendance (latest date): _____</p>
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<p>OUR USE ONLY:</p> <p>WE posted (date): _____</p> <p>WE, WEM Hold posted (date): _____</p>
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Petition for Withdrawal with Approved Excuse (Medical)

(Use only with "Medical" petition)

Request/Authorization, and Consent for Release of Records and Waiver
(Student completes and gives to Advisor)

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):

Name of Medical Provider: _____

Address: _____

Name of Medical Provider: _____

Address: _____

Name of Medical Provider: _____

Address: _____

For the purpose of evaluating a petition for a Withdrawal with Approved Excuse (WE) 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 Name _____
(Print)

Student Name _____
(Signature)

Temple ID Number _____
(9xxxxxxxx)

Date _____



Petition for Withdrawal with Approved Excuse (Medical)

(Use only with "Medical" petition)

Medical Provider's Statement to Support a Petition for Withdrawal with Approved Excuse:

Your patient is a student at Temple University and is seeking a 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 withdrawal from classes. This form must be returned to the student to accompany his/her Petition for a Withdrawal with Approved Excuse for a Medical Condition.

Thank you for your assistance.

Full name of patient: _____

Did you provide treatment for the above named patient? Yes No

If yes, nature of medical condition:

Date treatment started? _____ Date concluded (if applicable) _____

In your professional opinion, when was the student last able to attend class? _____
(Date)

How does his/her condition affect his/her ability to attend classes?

Print your name: _____

Your role in the treatment of this student is as a:

Medical Doctor _____ Psychiatrist _____ Psychologist _____ Other _____

Print your name: _____

Signature: _____ Date: _____

License Number and State: _____

Telephone Number: _____



Petition for Withdrawal with Approved Excuse (Medical)
(Use only with Medical Condition petition)

Medical Provider's Statement to Return to Temple University after a Withdrawal with Approved Excuse for Medical Reason:

Your patient seeks to return to Temple University after withdrawing in a previous semester as a result of a medical condition. As the medical doctor, psychiatrist, psychologist, or other licensed medical practitioner who is/has been treating the student for the medical reason necessitating a withdrawal from classes, please complete the form and return it to the student. If additional space is needed, please use the back of the form. The completed form is required for the student to be considered for active status at the University.

Thank you in advance for your assistance.

Full name of patient: _____

Did you provide treatment for the above named patient? Yes No

If "yes", please complete the following:

- What is the nature of medical condition (reason for previous withdrawal from the University and treatment): _____
Date treatment started? _____ Date concluded(or ongoing?) _____
How did the condition affect your patient's ability to attend school? _____

Do you believe that your patient is now able to safely participate in

- University classes as a full-time student? Yes No
University classes as a part-time student? Yes No

If you answered "no" to any of the above, please explain:

If your patient is approved to return to the University, do you have any specific recommendations:

Yes No

If you answered "yes", please explain: _____

Your role in the treatment of this student is as a:

Medical Doctor _____ Psychiatrist _____ Psychologist _____ Other _____

Print your name: _____

Signature: _____ Date: _____

License Number and State: _____

Telephone Number: _____