Medical Withdrawal - Healthcare Provider Release Information

Purpose: Used as an attachment to the Medical Withdrawal Request form.

Student Instructions:

1. Complete Sections 1 & 2 of this form using a computer.
2. Print the form using the 'Print Form' button.
   a. **a handwritten form will not be accepted.**
   b. an incomplete form, or a form without the required documents attached will not be processed and will be returned to you for completion.
3. Sign the form in Section 3; a digital signature is **not** acceptable.
4. Attach the following documents located on the Marquette Central web page (Forms - Academic):
   a. The Medical Withdrawal Release form (to be used should university personnel need to speak to the health care provider).
   b. Other required documentation.
5. Submit the forms/documentation via one of the methods listed at the bottom of this form.

Note: The information provided by this release must be provided by a licensed healthcare provider and will be kept in the strictest of confidence and used only as necessary when making a determination of the specific medical withdrawal listed below. If sufficient information to make a decision about the medical withdrawal is not provided in the statement from the healthcare provider, a representative from the Medical Withdrawal Committee may contact the student's healthcare provider for more information.

Section 1: Student Information

Name
Last name, First name, Middle name _____ MUID _____

Mailing Address
street, city, state, zip code _____

Phone _____ Email _____ @marquette.edu

Section 2: Licensed Healthcare Provider Information

Full Name _____

Title _____ Clinic/Hospital Name _____

Mailing Address _____ Phone _____

Print Form

Section 3: Statement and Signatures

I, the above name student, have applied for an official medical withdrawal from Marquette University on _____ for the following medical reason(s)
date of submission

_____

and hereby authorize the above named healthcare provider to release to a member of the Medical Withdrawal Committee, any information contained in my records relating to this specific medical withdrawal or my subsequent return to Marquette University, should further information be needed to act upon my request.

Student's Signature _____ Date _____

Hand Deliver: Marquette Central, Zilber Hall, 121, 1250 West Wisconsin Avenue, Milwaukee, WI 53233
Mail: Marquette University, Marquette Central, P.O. Box 1881, Milwaukee, WI 53201-1881
Email: medical.withdrawal@marquette.edu