# CATASTROPHIC WITHDRAWAL REQUEST – MEDICAL

A Catastrophic Withdrawal Request may be submitted in circumstances outside the student's control in which serious illness or accident prevents the student from continuing classes, and Incompletes or other arrangements with the instructors are not possible. Catastrophic Withdrawal is intended to be considered on a case-by-case basis; it is not intended to be used more than once. Normally, consideration is for a complete withdrawal from a given term. All requests for catastrophic withdrawal require thorough and credible documentation. If approved, Catastrophic Withdrawal will be noted on the transcript with a symbol of **WE**. If it is necessary for a student to be out more than one semester, the student may be eligible for an Educational Leave. For details, visit the Enrollment Services website.

**DEADLINE:** The Catastrophic Withdrawal Request must be submitted as early as possible after the catastrophic event has occurred but no later than the last day of classes in the term in which the event occurred.

**PROCEDURE:**

1. Complete and sign Part I.
2. Complete the appropriate Petition to Withdraw and obtain the required signatures.
3. Have this form completed and signed by your health care provider (Part II on reverse) in order for your appeal to be considered. Your health care provider may submit this information directly to Enrollment Services via FAX (562-985-4973).
4. All information must be submitted as soon as possible but no later than the last day of classes of the requested withdrawal term.
5. If you are receiving financial assistance, you are strongly encouraged to consult with a Financial Aid Officer to identify and understand the financial aid and monetary implications of submitting this withdrawal appeal.

**PART I - to be completed by student (please print)**

**Last Name:**_____ **First Name:**_____ **MI:**_____

**Campus ID Number:**_____ **Email Address:**_____

**Street Address:**_____ **City:**_____ **Zip:**_____

**Telephone:**_____ **Currently hold F1 or J1 Visa: Yes:** ☐ **No:** ☐

**Term of Requested Catastrophic Withdrawal:**

**Fall 20**_____ **Winter 20**_____ **Spring 20**_____ **Summer Session 20**_____

**Please read carefully before signing below:**

- ✓ I understand that both sides of this form must be completed in full and submitted by the deadline.\
- ✓ Faxed or photocopied forms from me are not acceptable and will result in denial of this appeal.
- ✓ If approved, symbols of **WE** will be posted to my academic record.
- ✓ The **WE** units will not be subject to CSULB's Undergraduate Withdrawal Limit.
- ✓ A refund, if any, will be calculated according to the California Code of Regulations.
- ✓ I may be required to obtain clearance from an appropriate medical professional prior to subsequent enrollment.
- ✓ Financial Aid recipients may have to repay all or part of their award; I have conferred with the Financial Aid Office.
- ✓ Approval of this appeal may affect visa status for international students. If applicable, I will contact International Student Services at CIE-Student@csulb.edu.
- ✓ Falsification of information may lead to disciplinary action by the University.

I commit that I have read the withdrawal policy and understand the possible ramifications on Financial Aid.

By signing this form, I authorize my health care provider to release necessary information to the University related to this appeal. Furthermore, I understand that my health care provider may be contacted for verification purposes.

**Student Signature:**_____ **Date:**_____

***Office of the Provost:***

☐ **Approved** ☐ **Approved with Hold** ☐ **Denied**

Signature: _____ Date: _____

***Office of Enrollment Services, Brotman Hall Rm123, 1250 Bellflower Blvd., Long Beach, CA 90840-0106***

***Phone: 562-985-5471 Fax: 562-985-4973***

## CATASTROPHIC WITHDRAWAL REQUEST – MEDICAL
## HEALTH CARE PROVIDER STATEMENT

**Student Name:** _____ **Campus ID**: _____

is requesting a Catastrophic Withdrawal for medical reasons from ALL courses in the indicated term at California State University, Long Beach and has authorized you to release information (see reverse). This form must be completed and submitted to Enrollment Services by a licensed health care provider (FAX: 562-985-4973) before the requested withdrawal can be considered. You may be contacted to verify the information provided.

**PART II – to be completed by Health Care Provider (please print)**

**Name of Health Care Provider:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone Number:** _____

1) **Last date the student was able to attend class:**

_____

2) **Date of onset of serious illness:**

_____

3) **Date(s) of medical care (start and end dates):**

_____

4) **General restriction(s) of student's medical condition:**

_____

_____

5) **Why / how did medical condition prevent completion of student's course work:**

_____

6) **Date of student's anticipated return to school:**

_____

**Authorized Health Care Provider Signature:** _____

**License #:** _____ **Date:** _____