



General Information

Last Name	First Name	M.I.	Major	Academic Level	Last 4 of Student ID Number
Term (Check ONE term per form): <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Summer (S1, S2, and S3) <input type="checkbox"/> Winter				Year Associated With Request	

I am requesting Dr. _____ to release the information requested below to Virginia Tech for the purpose of supporting a medical resignation or academic relief.

Signed _____ Date _____
(Student or Proxy)

The student listed above is seeking to receive a medical withdrawal or the removal of earned grades at Virginia Tech. The student feels a medical condition may have directly or indirectly affected their ability to be academically successful. At the student's request, we would appreciate your cooperation in answering the following questions. Thank you for your assistance in this matter.

Health Care Provider's Name: _____
 Health Care Provider's Type (credentials): _____
 License Number and State: _____
 Health Care Provider's Address: _____
 Health Care Provider's Telephone Number: _____

Specific dates you treated this patient: _____

In your professional opinion, was there a time period that the student was unable to attend class:
 Yes _____ No _____

If yes, please provide specific dates (MM/DD/YYYY): FROM _____ TO: _____

Would this medical condition affect the student's ability to study or engage in class activities for a period of time?
 Yes _____ No _____

In your opinion is/was the student unable to be academically successful due to a medical issue?
 Yes _____ No _____

Additional Comments: (please provide additional information on health care provider's letterhead if space on this form is insufficient).

Health Care Provider's Signature: _____ Date: _____