COMMUNITY COLLEGE
OF ALLEGHENY COUNTY

**Disability Resources and Services**
808 Ridge Avenue
Pittsburgh, PA 15212
412.237.4612
Fax: 412.237.2721

FALL _____

SPRING_____

SUMMER _____

# REQUEST FOR MEDICAL WITHDRAWAL

## Student Certification

**MEDICAL WITHDRAWALS SUBMITTED PRIOR TO THE REGULAR WITHDRAWAL DEADLINE WILL BE PROCESSED AS A REGULAR WITHDRAWAL FOR HEALTH REASONS.**

**STUDENT RESPONSIBILITIES:**

1. **Contact the Financial Aid Office** at any campus to determine if or how a Medical Withdrawal could potentially deem you ineligible to receive future aid. **You will be financially responsible for any outstanding charges to your student account.**
2. Students should complete the Request for Medical Withdrawal—Student Certification. Have your physician or licensed professional complete the Request for Medical Withdrawal—Physician/Mental Health Professional Certification.
3. Return both completed forms to disabilityservices@ccac.edu or fax to one of the DRS fax numbers listed above. **Both forms must be received by the college before any requests for medical withdrawals can be processed. Medical withdrawal forms must be submitted from the student's CCAC academic email address or accompanied by a valid photo ID.**

**GENERAL INFORMATION:**

- To maintain student confidentiality, courses identified on the petition for Medical Withdrawal are marked as "W" on academic transcripts and are considered an attempt to successfully complete the course. No additional notation is specified on the academic transcript indicating a student withdrew from a course due to medical reasons.
- **Medical withdrawals are intended for medical circumstances that occur after the regular withdrawal deadline.** Medical withdrawals submitted prior to the regular withdrawal deadline will be processed as a regular withdrawal for health reasons. Medical withdrawals must be submitted by "**the last day of class per student's schedule**" for the semester in which the medical situation occurred. The last day of class may not be the same for all courses on your schedule. If the end date has passed, you will not be eligible to petition for a Medical Withdrawal for those courses that have ended prior to receipt of completed Medical Withdrawal documents.
- The Directors of DRS will recommend approval or denial of the request based on the nature of the illness on the physician/mental health professional's statement. The physician/mental health professional's signature does not necessarily constitute approval. The college reserves the right to verify the authenticity of all requested information and signatures.
- **There is no adjustment to tuition and fees related specifically to a medical withdrawal. You remain financially responsible for all charges to your student account, and any adjustment of tuition and fees would follow the stated dates in the academic calendar and are in accordance with the college's drop policy.** The Financial Aid Office will adjust financial aid awarded in accordance with Federal guidelines and the Title IV Refund Policy for the semester for which the withdrawal is requested**.**
- Please reference the Community College of Allegheny County Student Handbook for complete Medical Withdrawal policy and procedure.

Student Name: _____ ID #: _____

Current Address: _____

Home Phone: _____ Alternative Phone:_____ Email: _____

**List each course to be included in the Medical Withdrawal below:**

| COURSE NUMBER | SECTION NUMBER | COURSE TITLE | CREDITS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Student Signature: _____ Date:_____

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# REQUEST FOR MEDICAL WITHDRAWAL

## Physician/Mental Health Professional Certification

Please return the completed Physician/Mental Health Professional Certification to disabilityservices@ccac.edu or fax to one of the DRS fax numbers listed above.

I authorize my physician/mental health professional to release the information requested for my medical withdrawal from the Community College of Allegheny County for this current semester. I understand that the information provided will be handled in a confidential manner and in compliance with HIPAA.

Patient Name: _____ ID #: _____

Student Signature: _____ Date:_____

**TO BE COMPLETED BY A QUALIFIED, LICENSED PROFESSIONAL**

Diagnosis:_____

Dates under your care for this particular illness: _____

Hospitalization date(s), if applicable: _____

Reason why this student is unable to complete the academic semester due to this particular illness:

Physician/Specialist: _____ Professional Credentials: _____

Address: _____ Phone: _____

Physician/Specialist Signature: _____ Date:_____

Professional License ID #: _____