

Health Care Provider Verification

Student Name: _____

The University of Washington Bothell has Petitions Policies allowing students experiencing a physical or mental debilitation or some other extenuating circumstances beyond their control to withdraw or request forfeiture money returned from a course(s) after the published deadlines. This policy is designed to allow for situations that arise during the quarter.

In order for the Petition Committee to make an assessment of the student's petition we are asking a statement be provided on office letterhead including the following:

- a) Your name
- b) Student's full name
- c) Date(s) student consulted with or sought treatment by you
- d) Brief statement of medical situation, including dates, and how this situation impacted the student's ability to successfully complete his or her academic obligation.

All information provided is kept strictly confidential. Please call if you have any questions.

Contact Information

Name of Health Care Provider: _____

Practice/Hospital Name: _____

Address: _____
(Street)

(City) (State) (Zip Code)

Phone: _____ Fax: _____

Please return this form to: University of Washington Bothell
Office of the Registrar, Box 358500
18115 Campus Way N.E.
Bothell, WA 98011-8246
(425) 352-5240 fax (425) 352-5455
uwbregistrar@uwb.edu