HEALTHCARE PROVIDER FORM

Instructions for Completing this Form
The University of Washington has a Hardship Withdrawal Policy allowing students experiencing physical or mental debilitation or some other extenuating circumstances beyond their control to withdraw from a course(s) after the published deadlines. This policy is designed to allow for situations arising after the 14th calendar day of the quarter.

If a Hardship Withdrawal Petition is approved, the student's transcript record is altered which will result in replacing the student's grade with an HW (indicating hardship withdrawal) grade.

In order for the Hardship Withdrawal Board to make an assessment of the student's petition we are asking that the following information be provided. Please be aware that this document is considered substantiation of a student's request to alter their permanent academic record

Please note: This form should only be completed by a qualified professional who is licensed and properly credentialed to diagnose and treat the stated condition(s). *All information provided is kept strictly confidential.*

Once this form has been completed it should be submitted to the UW Bothell Registrar's Office. The student can attach this form with their Hardship Withdrawal Form, or it can be turned in directly by the healthcare provider via the contact information below:

University of Washington Bothell
Office of the Registrar
18115 Campus Way NE, Box 358500
Bothell, WA 98011

Phone: 425-352-5240
Fax: 425-352-5455
Email: uwbreg@uw.edu

STUDENT INFORMATION (UW Student Completes This Section)		
Name (Last) (First) (M. I.)		Phone
Student ID Number	Email	Quarter being petitioned

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____, give my permission for my Health Care Provider to release information to the University of Washington Bothell concerning my physical condition.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent or Guardian (if student is under the age of 18) Date

HEALTHCARE PROVIDER INFORMATION (Healthcare Professional Completes This Section)		
Name		Credentials and Licensing Information:
Address		
Phone	Fax	Email

MEDICAL HARDSHIP ASSESSMENT (To be completed by a qualified healthcare provider)
1. What is the specific diagnosis/health condition?
2. When was the diagnosis(es) made?
3. When did you see the student in relation to the quarter under petition? Please list dates.
4. Please describe the symptoms of the stated diagnosis(es) this student experienced. *Example: Student's dominant wrist was immobilized.*
5. What symptoms or effects of the stated diagnosis(es) did the student experience that affected their ability to complete the course(s) being petitioned and/or to withdraw from the course by the appropriate University deadlines? *Note: may include reactions to medication/treatment, and unforeseen complications.*

By signing below I am verifying that the diagnosis(es) and supporting information provided above is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature:_____ **Date:**_____