UNIVERSITY OF WASHINGTON BOTHELL

Former Quarter Drop/ Tuition Forfeiture Healthcare Provider Form

INSTRUCTIONS FOR COMPLETING THIS FORM:

A Former Quarter Drop (FQD) or Tuition Forfeiture (TF) petition(s) may be granted by the UW Bothell's Petitions Committee if a student is **experiencing extenuating circumstances beyond the student's control**.

A licensed healthcare provider may complete this form as a supporting document to accompany a student's FQD petition. Examples of licensed healthcare providers include mental health counselors (LMHC), social workers (LICSW), marriage and family therapists (LMFT), psychologists (Ph.D. or Psy.D.), nurses and nurse practitioners (RN or NP), physicians (MD or ND), and any other licensed health/mental health provider. Trainees may also complete this form if co-signed by a licensed provider.

Once the form has been completed, it should be returned to the patient to submit to the University of Washington or it can be emailed directly to the UW Bothell: uwbreg@uw.edu.

TO BE COMPLETED BY THE STUDENT:

Student Name (Last)	(First)	(Middle Initial)
UW Student ID Number	Email	
FQD/TF Petition Quarter Summer (June-Aug)/Year______ Autumn (Sept-Dec)/Year______ Winter (Jan-Mar)/Year_________ Spring (Apr-June)/Year_______	I, ____ give my permission for my Health Care Provider to release information to the University of Washington Bothell concerning my physical/mental condition as It relates to my request for an FQD or TF petition(s). Signature of Student Date	

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL:

Description of Student/Patient's condition and how it prevents the student from attending their course(s).	
Date of first visit:	Date(s) seen during the quarter they are petitioning:
Healthcare Provider Name	Credentials and Licensing Information
Healthcare Practice/Facility Name	
Address/Website	
Phone	Email

I support the above student's petition for a Former Quarter Drop (FQD) or a Tuition Forfeiture Petition for the quarter indicated above due to extenuating circumstances beyond the student's control (check one): ☐ Yes ☐ No

Healthcare Provider Signature: ____ Date ______________

Licensed Supervisor Printed Name and Credentials (if applicable): ______________________________________

Licensed Supervisor Signature (if applicable): ____