

MEDICAL PROVIDER OFFICE LETTERHEAD

(DATE)

To the Dean of Students and Medical Withdrawal Review Committee,

(STUDENT'S FULL NAME) has been a patient under my care since (INITIAL DATE OF TREATMENT), when (HE/SHE/THEY) began treatment for (DIAGNOSIS/DIAGNOSES). Since our initial appointment, (STUDENT'S FIRST/PREFERRED NAME) has attended subsequent appointments on (LIST PREVIOUS APPOINTMENT DATES). Symptoms of (DIAGNOSIS/DIAGNOSES) include (LIST OF SYMPTOMS). I believe that these symptoms have significantly impacted (STUDENT'S FIRST/PREFERRED NAME)'s academic performance and ability to fully participate in classes during the (ACADEMIC TERM) semester. (STUDENT'S FIRST/PREFERRED NAME) indicated that (HE/SHE/THEY) is/are planning to apply for Current Semester Medical Leave/Withdrawal at the University. The last day that (HE/SHE/THEY) was/were able to successfully attend class was (LAST DATE OF ATTENDANCE). If granted Medical Leave/Withdrawal, it is my opinion that (STUDENT'S FIRST/PREFERRED NAME) will be able to return to the University during the (PROVIDER'S RECOMMENDED SEMESTER OF RETURN TO CAMPUS) semester. If you require additional information related to (STUDENT'S FIRST/PREFERRED NAME)'s course of treatment, or have further questions, please contact me directly at (PROVIDER'S PHONE AND/OR EMAIL ADDRESS). Thank you in advance for your consideration in this matter.

Sincerely,

(PROVIDER'S NAME)

(PROVIDER'S TITLE)

(PROVIDER'S SIGNATURE)