# 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 Retroactive Medical Withdrawal at the University. The last day that **(HE/SHE/THEY)** was/were able to successfully attend class was **(LAST DATE OF ATTENDANCE)**. 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)**