

## Medical Withdrawal Healthcare Provider Verification

## STUDENT INFORMATION

Name:	First	M.I.	Student I.D. (8 digit)
Arizona email:			
Term(s) affected (ex. Fall 2023)			
Term(e) uncered (ex. 1 all 2020)	<u>-</u>		
	HEALTHCARE PROV	IDER USE ONLY	
I,healthcare professional and the condition that impacted their ab	(print name above-named student is (cillity to participate and perfo	e and credentials) verify to or was) under my profess orm as expected in their e	hat I am a licensed ional care for a health ducation.
Date of onset of the health-	related circumstances	that led to the reques	t for withdrawal:
	*REQUIRED		
The following impact applies to	this student for the terms id	lentified above (please ch	neck one):
This condition prevented the in the affected term(s) This condition prevented the affected term(s)			
Other. You can provide cor personal health information of the		options are not relevant.	Please do not disclose
Healthcare provider signature		Date	
State and license number			
Address		Office phone	
City, State, ZIP code			