AUBURN UNIVERSITY | OFFICE OF ACCESSIBILITY

# Medical Resignation/Withdrawal Intake

Name: Date:

Phone #: Auburn University Email:

College: Major:

Do you plan to return to Auburn? Yes ☐ If yes, what term?

Have you requested a medical resignation/withdrawal before? Yes ☐ If yes, what term?

Semester for which you are requesting a medical resignation/withdrawal:

**Select from below all that apply**:

Financial Aid: ☐

International Student: ☐

On-Campus Housing: ☐

Varsity Athlete: ☐

Scholarship: ☐

**REQUIRED:** List your courses, the last date you attended (approximate if necessary) and your estimated grade at the time of last attendance

| Course Name: | Last Date Attended: | Grade: |
|---|---|---|
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**Briefly explain the reason for your medical resignation/withdrawal request:**

I understand that a medical resignation/withdrawal may have a significant impact on my financial aid, veteran's benefits, International Student status, eligibility for varsity athletics, on-campus housing, and/or registration.

I Agree ☐

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# Confidentiality of Records and Release of Information

**Records/Documentation**

Our office is committed to protecting the confidentiality of student records in our possession. We retain student records in compliance with both state and federal law, in particular with the Family Education Rights and Privacy Act (FERPA). The information contained within a student's file is property of the Office of Accessibility; however, a student can request to view his/her file in the presence of the Director, Assistant Director, or Medical Resignation/Withdrawal Coordinator. Medical documentation submitted to support a medical resignation or withdrawal request will not be forwarded to an off-campus third party for any reason, even with a written request from the student. Students are strongly encouraged to make a copy of the medical documentation for their personal records.

For more information or if concerns exist about the confidentiality of medical documentation, please contact the Office of Accessibility and speak with the Director, Assistant Director, or Medical Resignation/Withdrawal Coordinator.

I understand the information presented above. ☐

**Permission to Discuss Information**
**Non-University: Parents, Guardians, Spouses, etc.**

I give the Office of Accessibility permission to confer with the following individuals concerning my medical resignation or withdrawal request:

Full Name Relationship Phone#

**Permission to Discuss/Release Information**
**Academic and Administrative Purposes Only**

I hereby give the Medical Resignation/Withdrawal Coordinator permission to confer (via written and/or oral communication) with my advisor, instructors, Office of Accessibility administrative and professional staff, University staff, and/or administrators to facilitate my medical resignation or withdrawal request. I understand there are specific but rare instances when information regarding the medical nature of my resignation or withdrawal request may need to be disclosed to one of the above mentioned parties, i.e. for review by a specified member of Student Financial Services to determine any financial implications related to the request, for review by the Retroactive Resignation/Withdrawal Committee, or in the event of a direct threat or danger to myself or others.

I Agree ☐

I hereby release Auburn University, its Agents, Trustees, Officers, and Employees of liability of any nature arising from the disclosure of this information on my behalf and at my request.

I Agree ☐

Clear Form

Print

Email

**Signature** **Date**