MEDICAL WITHDRAWAL

FROM INDIVIDUAL COURSES

Accessibility Services
AccessibilityServices@royalroads.ca
Phone: 1.800.788.8028 Fax: 250.391.2670
2005 Sooke Road Victoria BC V9B 5Y2

STUDENT INFORMATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

The personal information collected on this form is collected under the authority of the University Act and is subject to the Freedom of Information and Protection of Privacy Act. The personal information collected will be used for assessing medical needs, in relation to withdrawing from individual courses and potential academic accommodations. For more information regarding the collection and use of personal information please contact Royal Roads University's Privacy Officer at 250 391-2600 (ext. 4178) or via email at: info@royalroads.ca, or in writing at above address.

STUDENT IDENTIFICATION

I hereby authorize my health care practitioner to complete this form and to fully respond to the requested statement questions below as they relate to assessing Authorized Withdrawing from Individual courses and other supports directly related to medical barriers to education at Royal Roads University. Any fees incurred for completion of this form are my responsibility. I also understand this **form must be submitted** to Accessibility Services **prior to the course end date** to be considered for the academic and financial considerations of medically dropping class(es).

Student Name: _____Signature:_____

Student Number: _____Program: _____Date: _____

HEALTHCARE PRACTITIONER STATEMENT

I recommend that the above-named student be withdrawn from individual courses due to the following medical condition, illness or disability: _____

_____

Please list the course(es) to be withdrawn. Note: students may only medically withdraw from the same course twice.

Course ID	Course Description	Recommended Withdrawal Date

Would academic accommodations also assist this student in their active classes? Yes ☐ No ☐

Time and a half for exams? Yes ☐ No☐

More time for individual assignments? Yes ☐ No☐

Please note: extension timelines vary by program.

Other comments: _____

HEALTHCARE PRACTITIONER IDENTIFICATON

Name: _____

Specialty/Occupation: _____

Signature: _____ Date: _____

Address: _____ Phone: _____