SMU Medical Withdrawal Statement of Understanding

I, *(print name)* _____, am requesting a Medical Withdrawal, which will be granted by the Caring Community Connections team, if approved.

I have discussed the following: *(initial next to each statement below)*

_____ I understand the academic implications of a medical withdrawal.

_____ I understand that if approved for a medical withdrawal, a hold will be placed on my account and any subsequent enrollment I have will be canceled until I request and am cleared to return.

_____ I understand that I may be out for at least the full immediate semester following my withdrawal.

_____ I understand that I will need to contact my financial aid advisor to discuss any implications to my aid if I am receiving financial aid.

_____ If I live on campus, I understand that I will need to formally check out of my room within 48 hours of my withdrawal. I will contact my Residential Community Director (RCD) and arrange a check out appointment.

_____ I understand the responsibility to seek appropriate treatment and care and that my return is contingent on this treatment and the recommendations of my provider.

_____ I understand that there is a process for return, that I should contact the Dr. Bob Smith Health Center to start this process, and that I will need to abide by deadlines for my return.

_____ I have reviewed the Medical Withdrawal Checklist with a staff member.

_____ I understand that if I am not granted a medical withdrawal, I can work with the Office of Student Success and Retention to take a leave of absence.

In addition to official communication that will be sent to my SMU email, should someone need to reach me about my medical withdrawal request, please use this alternative email address and/or phone number:

_____ _____

Email Phone

_____ _____

Student Name (printed) SMU ID Number

_____ _____

Student Signature Date