This Request is for Withdrawal from ALL classes

All Completed forms with required documents must be returned to the
ASSOCIATE VICE PRESIDENT & DEAN OF STUDENTS OFFICE
FLORIDA ATLANTIC UNIVERSITY
777 GLADES ROAD, SS # 8, ROOM 226
BOCA RATON, FL 33431

COMPLETE WITHDRAWAL REQUEST PACKETS submitted are for ALL classes and should be submitted during the semester for which the withdrawal is requested and at least two (2) weeks prior to the last day of classes. INCOMPLETE PACKETS will be returned. Applications received after the submission deadline may be considered if the student’s documents show that the failure to apply timely was beyond the control of the student.

Qualifying Reasons for an Exceptional Circumstances Withdrawal are:

A. Physical/Mental Illness or Injury: Illness of a student of such severity or duration, to preclude completion of all courses.
B. Death in the Immediate Family Members ONLY – Parents, Spouse, Sibling, Grandparent, Child, or Legal Guardian (papers required).
C. Involuntary call to Active Military Duty ONLY.
D. Primary Care-Giver to ill Immediate Family Member—(Refer to Item B above for immediate family list)
E. Victim of Crime
F. Other

Complete Packet Includes:

1. Request for Exceptional Circumstances Withdrawal Form: The student is required to complete and sign the form.
2. Letter of Explanation: A letter, written, signed & dated by the student, explaining the reason for the withdrawal request.
3. Release of Medical Information (if Applicable): The student is required to complete and sign the form.
4. Acceptable documentation for one of the following:
   Physical/Mental Illness or Injury:
   • Physician / Clinician must complete the Medical Certification Form provided by FAU. This form must be completed in its entirety for submission.
   • Physician / Clinician must state that condition prevents successful completion of ALL courses and the reason(s) why.
   Death in Immediate Family:
   • Requires Death Certificate or a letter from funeral director or obituary.
   Military:
   • Requires copy of Military Orders
   Primary Care-Giver to ill Immediate Family Member:
   • Physician/Clinician of Family Member must complete the Primary Caregiver Certification Form provided by FAU.
     This form must be completed in its entirety for submission.
   • The reason(s) the family member’s condition prevents the student’s successful completion of all course work.
   Victim of Crime:
   • Letter from Victim Advocate and/or Police report
   • The reason(s) the crime prevents the student's successful completion of all course work.
   Other:
   • On a case by case basis

Completed packet will be submitted to the Exceptional Circumstances Withdrawal Committee (ECWC) for review. The ECWC, which includes health care professionals, meets weekly and will determine if there is just cause for a withdrawal due to exceptional circumstances. You will be notified electronically via your FAU campus email.

In ALL cases of Medical/Mental illness Withdrawals, an administrative hold may be placed on the student's upcoming registration until clearance is given by the attending physician/clinician, in writing, stating that the student is now well enough to return to school. The ECWC will determine whether or not the student can resume classes for the upcoming semester. If it’s the summer it will be 1, 2, & 3. If the withdrawal is approved, a "WM" will replace the grades, and there may be a refund of your tuition. You should meet with Financial Aid, Housing, or Business Services (meal plan) to determine the impact of your withdrawal.

Documentation MUST be in English or be translated into English, and the translator's signature must be notarized. The translator must be someone other than the student or a relative of the student.

Student Appeal Process:
Students who are denied Exceptional Circumstances Withdrawal may appeal the decision to the Sr. VP of Student Affairs, in writing, within ten (10) business days of receipt of ECWC response letter.

April 2013
FLORIDA ATLANTIC UNIVERSITY
REQUEST FOR EXCEPTIONAL CIRCUMSTANCES
WITHDRAWAL FORM
ASSOCIATE VP & DEAN OF STUDENTS OFFICE, SS # 8, Room 226, 777 GLADES RD, BOCA RATON, FL 33431

1. GENERAL INFORMATION (Incomplete Forms Will Not Be Processed)

STUDENT Z# ________________________________ Click Here To Find Z# __________________________ (Website: myfau.fau.edu)

LAST NAME: __________________________________________ FIRST NAME: __________________________

ADDRESS: __________________________________________

CITY: __________________________ STATE: __________________________ ZIP: __________________________

DAYTIME TELEPHONE: (________) E-MAIL __________________________

2. WITHDRAWAL INFORMATION (Please Check One) (Complete this Section)

☐ MEDICAL WITHDRAWAL
☐ DEATH IN IMMEDIATE FAMILY
☐ MILITARY
☐ VICTIM OF CRIME
☐ PRIMARY CARE-GIVER
☐ OTHER

SEMESTER WITHDRAWING FROM: __________________________ YEAR: ______

BY SIGNING THIS FORM, I UNDERSTAND THAT I AM REQUESTING WITHDRAWAL FROM ALL OF MY CLASSES FOR THE SEMESTER, WITHOUT EXCEPTION.

The Exceptional Circumstances Withdrawal Committee, which includes health care professionals, may decide that the student be required to stay out for a semester or longer if it is deemed to be in the best interest of the student/or the university. You will be notified electronically via your FAU campus email.

YOUR SIGNATURE: __________________________ DATE: __________________________

COMMITTEE USE ONLY

☐ APPROVED or ☐ DENIED

CURRENT ACADEMIC STATUS: __________________________ CREDITS DROPPED: __________________________

PREVIOUS WITHDRAWALS: __________________________

☐ FINANCIAL AID Date: __________________________

☐ REGISTRAR Date: __________________________

☐ CASHIER Date: __________________________

STAMP DATE: __________________________

COPIES TO: ☐ HOUSING ☐ OSD ☐ VETERANS ☐ ISSS May 2012
FLORIDA ATLANTIC UNIVERSITY
RELEASE OF MEDICAL INFORMATION FORM

RELEASE OF MEDICAL INFORMATION
To Verify authenticity of Medical Documents

I hereby authorize and instruct the physician named below to release all information from my medical records which pertain to my request for a medical withdrawal, to the Associate Vice President & Dean of Students Office of Florida Atlantic University.

PHYSICIAN NAME: ________________________________________________________________________________

PHYSICIAN ADDRESS: _____________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

PHYSICIAN PHONE NUMBER: ______________________________________________________________________

STUDENT SIGNATURE: _________________________________________     DATE: __________________________

STUDENT NAME (Please Print): _____________________________________________________________________

STUDENT Z NUMBER: ____________________________________________________________________________

THIS FORM MUST BE SUBMITTED IN CONJUNCTION WITH THE “REQUEST FOR EXCEPTIONAL CIRCUMSTANCES WITHDRAWAL FORM”.

THIS RELEASE IS IN COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND PRIVACY ACT (HIPPA).

THIS RELEASE IS GOOD FOR 90 DAYS FROM STUDENT’S DATED SIGNATURE ABOVE.

Completed forms with required documents must be returned to the
ASSOCIATE VICE PRESIDENT & DEAN OF STUDENTS OFFICE
FLORIDA ATLANTIC UNIVERSITY
777 GLADES ROAD
SSB# 8, ROOM 226, BOCA RATON, FL 33431
Fax: (561) 297-2502

Sept 2008