



# FLORIDA ATLANTIC UNIVERSITY

## EXCEPTIONAL CIRCUMSTANCES WITHDRAWAL INFORMATION

### 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 semester end. 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's written statement must include: Diagnosis (DCM/ICD), prognosis and dates of treatment. Must be on Physician / Clinician's letterhead, and include the Physician / Clinician's name, title, date, and signature. Prescription pad note **WILL NOT** be accepted.
    - Physician / Clinician's 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:**
    - Letter from treating physician stating that student is primary care-giver.
    - 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 per 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.

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 five (5) business days of receipt of ECWC response letter.



# 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

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| ARE YOU RECEIVING FINANCIAL AID?                              | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| ARE YOU LIVING IN CAMPUS HOUSING?                             | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| ARE YOU AN INTERNATIONAL STUDENT?                             | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| ARE YOU RECEIVING VETERANS BENEFITS?                          | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| ARE YOU REGISTERED WITH OFFICE FOR STUDENT WITH DISABILITIES? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| ARE YOU COVERED BY HEALTH INSURANCE?                          | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

SEMESTER WITHDRAWING FROM: (MUST BE CURRENT) \_\_\_\_\_ 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.

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  ISS S



**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