MEDICAL AND EXCEPTIONAL WITHDRAWAL REQUEST/EXTENSION FEE WAIVER REQUEST

THOMPSON RIVERS UNIVERSITY
OPEN LEARNING

TRU-OL Office of the Registrar,
900 McGill Rd, Kamloops, BC V2C 0C8
Fax 250.852.6405 **www.truopen.ca**

GENERAL INFORMATION Use this form to request a:

- Withdrawal for medical or exceptional, long-term reasons from courses delivered by TRU-OL, SFU or UVic before the deadline stated in your welcome letter.
- One-time course extension with fee waiver for extension-eligible courses delivered by TRU-OL.

The information you provide on this form is collected under the Thompson Rivers University Act and the Freedom of Information and Protection of Privacy Act (BC) and will only be used to administer your request.

Refer to withdrawal and extensions policies, as follows:

- On the TRU-OL website at www.truopen.ca.
- In the TRU-OL Calendar.
- Contact Student Services via email at **student@tru.ca** or phone at 1.800.663.9711 (toll-free in Canada) or 250.852.7000 (Kamloops and International).

For medical withdrawal and medical-related fee-waived extension requests, your attending physician must complete the Physician's Statement on the form and fax or mail the completed form to the TRU-OL Office of the Registrar (above address). You may be required to supply additional information.

For other exceptional withdrawal and exceptional fee-waived extension requests, you should include the appropriate relevant documentation and statements with the completed form.

STUDENT PERSONAL DATA (STUDENT TO COMPLETE)

ENTER TRU-OL STUDENT NUMBER (PRINT CLEARLY)

SURNAME (legal)

FIRST NAME (legal) FULL MIDDLE NAME(S) (legal)

MAILING ADDRESS

MAILING ADDRESS (include buzzer code if applicable)

CITY / TOWN / VILLAGE

PROVINCE / STATE POSTAL CODE / ZIP CODE COUNTRY

HOME TELEPHONE NUMBER AREA CODE

BUSINESS TELEPHONE NUMBER AREA CODE LOCAL

EMAIL ADDRESS (print clearly)

REQUEST (STUDENT TO COMPLETE) **Check (√) one:**

I REQUEST TO BE CONSIDERED FOR A FEE-WAIVED EXTENSION FOR THE FOLLOWING COURSE(S) ☐

I REQUEST A WITHDRAWAL FOR MEDICAL OR EXCEPTIONAL REASONS FROM THE FOLLOWING COURSE(S) ☐

COURSE NUMBER	COURSE NAME

COURSE NUMBER	COURSE NAME

COURSE NUMBER	COURSE NAME

PERSONAL COMMENTS

PERSONAL COMMENTS

PERSONAL COMMENTS

STUDENT'S SIGNATURE	DATE

STUDENT'S CONSENT FOR SUBMISSION OF PHYSICIAN'S STATEMENT

I, _____ ,
HAVE REQUESTED AND CONSENT TO MY PHYSICIAN COLLECTING AND SUBMITTING PERSONAL INFORMATION TO TRU-OL FOR THE PURPOSES OF ASSESSING MY ELIGILIBILITY FOR SPECIAL CONSIDERATIONS

STUDENT'S SIGNATURE	DATE

*NOTE: PAGE 2 MUST BE COMPLETED BY YOUR PHYSICIAN