Medical and Exceptional Withdrawal 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

Students who are unable to complete a course due to long-term medical reasons or a personal emergency may use this form to apply for a medical and exceptional withdrawal.

A withdrawal with no grade reported is an extraordinary circumstance, typically granted for serious medical conditions or significant family or personal emergencies. To be eligible for a withdrawal, students must perform the following:

- Submit this form and supporting documentation before the course completion date.
- Have a physician complete the Physician's Statement on this form and fax or mail the completed form to the TRU-OL Office of the Registrar at the address provided above. This Statement must include the general nature of the student's medical condition and how it will prevent the student from completing course requirements.
- Supply additional information as requested.

Please note that course tuition and fees are not refunded in the event of a medical withdrawal.

Withdrawals submitted for medical reasons are subject to TRU policy and deadlines. Refer to the TRU-OL website, Regulations and Policies – 4.4 Withdrawals.

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.

For questions about this policy or this form, 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).

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 (include buzzer code if applicable)

CITY / TOWN / VILLAGE

PROVINCE / STATE POSTAL CODE / ZIP CODE COUNTRY

PRIMARY TELEPHONE NUMBER
AREA CODE LOCAL

SECONDARY TELEPHONE NUMBER
AREA CODE LOCAL

EMAIL ADDRESS (print clearly)

REQUEST (STUDENT TO COMPLETE):

☐ I REQUEST TO WITHDRAW FROM ALL OF MY COURSES FOR MEDICAL OR EXCEPTIONAL REASONS.

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 eligibility for special considerations.

STUDENT'S SIGNATURE	DATE

NOTE: THIS SECTION MUST BE COMPLETED BY YOUR PHYSICIAN

PHYSICIAN'S STATEMENT (ATTENDING PHYSICIAN TO COMPLETE)

PHYSICIAN NAME (please print)

MAILING ADDRESS (include buzzer code if applicable)

MAILING ADDRESS

MAILING ADDRESS

CITY / TOWN / VILLAGE

PROVINCE / STATE POSTAL CODE / ZIP CODE COUNTRY

BUSINESS TELEPHONE NUMBER
AREA CODE LOCAL

ALTERNATE TELEPHONE NUMBER
AREA CODE LOCAL

OR EMAIL ADDRESS

DATE OF EXAMINATION/CONSULTATION ON WHICH THIS REPORT IS BASED

IN MY OPINION, THIS STUDENT HAS BEEN /WILL BE UNFIT TO PURSUE ACADEMIC STUDIES DUE TO ILLNESS:

FROM (DATE) _____ TO (DATE) _____

RELEVANT INFORMATION (required field):

Please provide the general nature of the student's illness or condition and how or why it will prevent the student from completing the course requirements.

PHYSICIAN'S SIGNATURE	DATE