Lock Haven University

MEDICAL VERIFICATION FORM

Student Name:______________________________________ Date:________________________

The above named is a student at Lock Haven University, Lock Haven Pennsylvania. He/She is requesting a withdrawal from the University for medical reasons. It is the policy of the University to honor requests for non-penalty medical withdrawals provided the student's physician(s)/psychologist verifies the dates of treatment and nature of the illness or injury.

Illness:

____

____

____

____

____

Dates of Treatment:

____

____

____

Student's Signature:____
(I authorize my doctor to release the medical information regarding my illness or injury to University Officials.)

Signature of
Medical Professional
or Psychologist:____________________________________ Date:________________________

Physician Printed Name:

____

Address:____ City:________________________

State:______________ Zip:________________________ Phone:______________________

Please mail or fax this form within seven days to:

Kenneth Hall, Director of the Center for Excellence and Inclusion
Ulmer 135, Lock Haven University
Lock Haven, PA 17745 Fax: 570-484-2438
Phone: 570-484-2598 – Email: khall@lockhaven.edu