Lock Haven University

MEDICAL VERIFICATION FORM

Students must complete the Withdraw/Not Returning Form prior to submitting this form.

Please click on the following link: https://lockhaven.edu/registrar/withdrawform.html

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:

Registrar's Office
Lock Haven University
Lock Haven, PA 17745
Phone: 570-484-2006 Fax: 570-484-2734
Email: registrar@lockhaven.edu