



Students applying for a "Withdrawal under Extenuating Circumstances" DATE completed by Healthcare Provider \_\_\_\_\_  
are asked to submit this form if it will support their application. ALL INFORMATION MUST BE IN ENGLISH OR AN OFFICIAL  
TRANSLATION PROVIDED.

**APPLICANT**

Student's last name \_\_\_\_\_ Title  Mr  Mrs  Miss  Ms  
First name \_\_\_\_\_ Preferred name \_\_\_\_\_  
SFU student # \_\_\_\_\_

**HEALTH CARE PROVIDER**

How long has this student been a patient or client? \_\_\_\_\_

Please list dates that this student has been attended by you for this personal concern or illness. \_\_\_\_\_  
\_\_\_\_\_

How does this condition prevent the student from attending all or some university courses, classes, etc.?  
\_\_\_\_\_  
\_\_\_\_\_

In your opinion, what date will this student be able to return to university studies?  
\_\_\_\_\_  Full-time  Part-time

REMARKS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Title \_\_\_\_\_ Name \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Signature \_\_\_\_\_

PLEASE NOTE THAT, IF THERE IS A CHARGE FOR COMPLETING THIS FORM, THIS IS THE RESPONSIBILITY OF THE STUDENT.

**FREEDOM OF INFORMATION/PROTECTION OF PRIVACY**

The information on this form is collected under the authority of the University Act [RSBC 1996, C.468, s27 (4)(a)]. This information is used only in making the decision to approve or deny your request for course withdrawal for extenuating circumstances. If you have any questions about the collection and use of this information, contact the Assistant Registrar, Senate and Academic Services, 778.782.5350.

**By signing below I, the applicant, consent to the collection and use of personal information about me as noted above. I understand that failure to consent may result in rejection of my application for withdrawal.**

Signature \_\_\_\_\_ Date \_\_\_\_\_