Truman State University

Medical Verification Form

Student Name: ___________________________________ Date: _________________________

The above named is a student at Truman State University in Kirksville, MO. They are requesting a withdrawal from the university for medical reasons. It is the university's policy to honor requests for medical withdrawals provided the student's medical/mental health professional verifies the dates of treatment and the nature of the illness or injury.

Diagnosis/Symptoms Impacting Academic Functioning:

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____
____

Dates of Treatment:

____
____
____

Student's Signature: ____

(I authorize my medical/mental health professional to release medical information regarding my illness or injury to university officials)

Medical/Mental Health Professional Information

Signature: ____________________________ Printed name: _____________________________

Date: ___________________________ Phone: ____________________

Street: ___________________________ City: _________________ State: _______ Zip: _______

Please mail, fax, or email this form to:

Jonathan Vieker, Director of Retention and Student Success
Truman State University
100 E Normal St
Kirksville, MO 63501
Fax: (660) 785-4118
Email: appeals@truman.edu