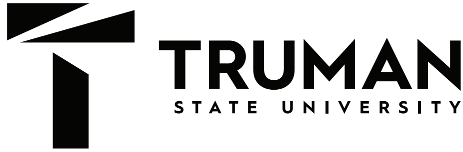

Medical Verification Form

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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____

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Dates of Treatment:

____

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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 email, drop off, or mail this form to:

Ashleigh Harding, Director of Student Success & Academic Standards Chair

Center for Academic Excellence, PML 109

Truman State University

100 E Normal Ave., Kirksville, MO 63501

Email: appeals@truman.edu

Phone: (660) 785-7403