MEDICAL/PSYCHOLOGICAL RELATED

Cancellation Request Part 2

MEDICAL HEALTH CARE PROVIDER COMPLETES AND SIGNS THIS PAGE
PLEASE PRINT OR TYPE

Student's Name: _____

To consider this student's cancellation request for medical and/or psychological reasons, Wayne State University requires current documentation of the student's medical and/or psychological condition(s) from a licensed clinical professional or health care provider thoroughly familiar with the student's condition(s). All items must be completed in full. If the spaces provided are not adequate, please attach a separate piece of paper.

Please respond to the following items regarding the student named above:

1) Student's medical/psychological condition/diagnosis: _____

   _____

   a) How long has the student had this condition: _____
   b) How long has the student been under your care: _____
   c) How long is this condition likely to persist: _____
   d) When was the student/patient last seen by you: _____
   e) What is the ongoing treatment plan: _____

2) Please explain why the student named above cannot live in an on-campus residence hall and specify why living off-campus is medically or psychologically necessary.

   _____

   _____

   _____

   _____

Signature of provider: _____ Date:_____

License #: _____ Issuing Authority: _____

(Please print or type) Name & Title: _____

Address: _____

Phone: _____ Email: _____

MEDICAL/PSYCHOLOGICAL RELATED

Cancellation Request Part 1

STUDENT COMPLETES AND SIGNS THIS PAGE
PLEASE PRINT OR TYPE

Name:_____
Last First M.I.

Banner ID#:_____

Home Address:_____

City:_____ **State:**_____ **Zip:**_____

My medical/health care provider is:

Name of Provider_____

Address:_____

City:_____**State:**_____ **Zip:**_____ **Country:**_____

We may need more info from a health care provider. I authorize the above shown provider to release information related to my petition to Wayne State University Housing and Residential Life Review Board, if necessary.

Student's Signature: _____ **Date Signed:**_____