

**Susquehanna University
Health/Mental Health Provider Form**

**To the Provider: Please complete this form and submit directly to:
Vice President for Student Life/Dean of Students FAX: 570-372-2863
Susquehanna University
514 University Ave.
Selinsgrove, PA 17870**

Provider name:	Profession and license #:
Provider address:	Provider phone:

Student name:	Date of requested withdrawal: Fall 20____ Spring 20____
Dates of visits:	Location of evaluation and/or treatment (e.g., office, hospital OP, hospital IP, etc.)

Indicate the specific medical findings, restrictions and/or other objective data that document how student's class attendance or participation was significantly impaired or obstructed during the above semester.

What alternatives to withdrawal, if any, have been considered or tried?

Signature

Date
