Medical Withdrawal Guidelines

Definition: A medical withdrawal is a withdrawal from classes due to a severe medical condition, either physical or emotional. It is intended for use only in extraordinary circumstances in which unanticipated serious illness or injury prevents a student from continuing to attend or participate in one or more classes.

Process:
1) Consult with an advisor and, if applicable, a member of the Financial Aid Office and/or Veterans Services staff, as well as Visa status for international students, to ensure that all ramifications of a medical withdrawal are clear.
2) Complete and submit Part 1 of the Medical Withdrawal process within 60 days of the date of the incident or start of the medical condition.
3) Health care provider submits the Health Care Provider Endorsement form within the 60 day time frame.
4) The request is reviewed and the decision will be sent to the student via mail.
5) Incomplete forms will be returned.

Questions: For questions about the medical withdrawal process, contact Anna Berry, Chief Student Affairs Officer via email (berrya@gcc.mass.edu) or telephone (413-775-1868). If not available, contact Holly Fitzpatrick, Registrar through email (fitzpatrickh@gcc.mass.edu) or telephone (413-775-1813).
Greenfield Community College
One College Drive, Greenfield, MA 01301-9739
(413) 775-1813
Office of the Registrar

Request for Medical Withdrawal – Part 1

Instructions: Complete both pages of Part 1 of the form, including last date of attendance. Return to Enrollment Services by using the secure upload link: [https://www.gcc.mass.edu/med](https://www.gcc.mass.edu/med), by mailing to the address above or by fax (413.775.1827). Please note that information sent by mail or fax will slow processing.

Student Name: ________________________________________________________

Student ID Number: ________________

I hereby request a medical withdrawal from the following term (write in year):

Fall _______ Spring _______ Summer I _______ Summer II _______

I request a withdrawal from:

___ All of my classes

___ Only the class(es) specified below: (required)

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<th>CRN</th>
<th>Course code (e.g. ENG 101)</th>
<th>Section</th>
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I have read the Medical Withdrawal Guidelines and understand that Medical Withdrawal decision are final with no appeal process. I certify that all of the information I have provided with this request is true and accurate to the best of my knowledge.

Student’s Signature: _________________________________________________

Date: ________________

For Office Use Only:
Medical withdrawal approved: Yes___ No___
Withdrawal effective Date: ________________
Chief Learning Officer or Designee: ________________________________ Date: ________
Student Name: ___________________________________________

Student ID Number: ________________

Please describe your justification for requesting a medical withdrawal in detail including the impact on your ability to complete your classes. If you are not dropping all of your classes, please explain.
The student named below is requesting a medical withdrawal from one of more courses at Greenfield Community College. The information you provide is used in considering the student’s request. The provided information does not become part of the student record. It retained in a separate, secure administrative file in the Chief Student Affairs Officer. Please return the completed form either using our secure upload link: https://www.gcc.mass.edu/med or by mail to the Enrollment Services, Attn: Anna Berry, Chief Student Affairs Officer, Greenfield Community College, One College Drive, Greenfield, MA 01301-9739. If the form is given to the student for delivery, please place in a sealed envelope and sign the outside seal and attach your business card to the form. Thank you for your assistance in this process. Incomplete forms will delay processing.

For the student: I hereby authorize the health care provider named below to release necessary medical information to Greenfield Community College to support my request for a medical withdrawal.

_______________________________  ________________________________  ___________________
Student’s Name (printed)       Student’s Signature       Date

For the health care provider:

______________________________________________________________  __________________
Health Care Provider’s Signature       Date

Please indicate below the start and end dates of the period when the student named above was incapacitated and unable to participate in normal class activities at Greenfield Community College due to his or her medical condition. Please indicate if the limitation is for all classes or only for specific classes and/or activities.

Start Date            End Date
If special circumstances apply, please describe those circumstances below. Use additional pages or attach additional documents, if necessary.

Description of Limitations:

___________________________________________________________________________

Health Care Provider’s Signature       Date