



Appeal for RETROACTIVE Withdrawal

After a term has ended, a student who left the university for extenuating circumstances without an official withdrawal during the term of departure may apply for a retroactive withdrawal. The student must present supporting documentation that demonstrates serious and compelling reasons justifying the withdrawal and extenuating circumstances justifying its retroactive nature; poor academic performance that is not attributed to non-academic extenuating circumstances is not a consideration for retroactive withdrawal. A student may appeal for a retroactive withdrawal within two calendar years following the end of the term for which withdrawal is requested. A student need not be enrolled at WKU at the time the application for retroactive withdrawal is submitted.

PROCEDURE:

1. Complete and sign Part I.
2. Provide a written statement that outlines the nature of your request for a retroactive withdrawal and the reasons you believe your appeal merits approval.
3. Submit a letter(s) of support from an academic administrator, faculty member, advisor or other university professional who is familiar with your situation. If the extenuating circumstance involves medical reasons, it is not necessary for the letter(s) of support to contain details of the medical condition.
4. If you are seeking a retroactive withdrawal for physical/mental illness or injury, you must have your physician/health care provider complete Part II of this form. Authorize your physician/health care provider to release your medical information by signing the statement at the top of Part II.
5. Submit the completed form and required documentation to Office of the Registrar, PH 216.

PART I - to be completed by student (please print)

Last Name: _____ First Name: _____ MI: _____

WKU Identification Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Enter Term of Requested Retroactive Withdrawal:

Fall Semester 20 _____ Spring Semester 20 _____ Summer Term 20 _____ Winter Term 20 _____

Please read carefully before signing below. I understand that:

- Part II of this form must be completed, in full, if my appeal is due to physical/mental illness or injury.
- I am not entitled to a refund of tuition and fees.
- I understand that if I received financial assistance for this term, funds may need to be returned to the appropriate program based on this withdrawal. (If you did receive financial assistance during this term, it is strongly recommended that you consult with a financial aid counselor to discuss the financial consequences of the withdrawal.)
- Approval of this request may affect visa status for international students (check with the Office of International Student and Scholar Services, if applicable, before withdrawing).
- Falsification of information may lead to disciplinary action by the University.
- An appellate board will review my request for a retroactive withdrawal. If approved, my instructors and department heads will be notified, and they will be given an opportunity to raise objections to the recording of a withdrawal grade.
- By signing Part II of this form, I authorize my physician/health care provider to release necessary information to the University related to this request, if applicable. Furthermore, I understand that my physician/health care provider may be contacted for verification purposes.

Student Signature: _____

Date: _____

Office of the Registrar

Approved: _____ Date _____

Office of the Registrar, Potter Hall 216, 1906 College Heights Blvd. #11017, Bowling Green, KY 42101-1017

Phone: 270.745.3352 Fax: 270.745.4830

Appeal for RETROACTIVE Withdrawal
Physician's/Health Care Provider's Statement of Serious Illness or Injury

A statement of illness or injury must be completed by a physician or licensed health care provider and submitted to the Office of the Registrar before the retroactive withdrawal can be considered. Permanent or temporary serious illness or injury is the only acceptable basis for a retroactive medical withdrawal.

I (student name) _____ am requesting a retroactive medical withdrawal from all courses in the _____ term at Western Kentucky University and am authorizing you to answer questions on this form.

Student Signature

Date

PART II - to be completed by Physician or Health Care Provider (please print)

Name of Physician/Health Care Provider: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

1. Describe the serious illness or injury that prevented the student from completing the term.

2. Why did this illness/injury prevent the student from completing the term?

3. When did this illness/injury occur? _____

4. Dates of examination for the condition claimed as the basis for the appeal:

Physician Signature: _____ Date: _____

License #: _____