DAWSON
C O L L E G E

REQUEST FOR AN AUTHORIZED ABSENCE FOR MEDICAL REASONS

Students must supply all required information before their request will be considered. Please print.

NAME: _____ STUDENT NO.: _____

ADDRESS: _____ PROGRAM NO.: _____

_____ TEL. NO.: _____

The deadline for dropping a course without receiving a failing grade is September 19 for the Fall and February 14 for the Winter semesters. After these dates an authorized absence may be requested only for serious medical reasons which prevented the student from attending school for more than **three weeks**, such as illness, or the illness or death of a spouse or family member. Other requests for an authorized absence will be considered only in exceptional cases for grave and serious reasons beyond the student's control.

Complete this form and attach original medical documents. Supporting documentation from an independent medical professional must specify nature and period of illness (onset of illness), degree of incapacity, treatment given or on-going, and/or when the student may resume his/her studies, and/or the prognosis. (You may have the doctor complete the reverse of this form). Students must submit their request before the end of the semester concerned. All information supplied will be treated confidentially.

Authorized absence requested for the following courses:

√	Course & Section No.	Course Name	Teacher	Semester	Number of Classes Missed
	Ex. 603-102-04-03	*English*	*Mr. Teacher*	*Fall 05*	*8*
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Date illness began _____ Length of illness _____

Reason for request for medical withdrawal:

_____

_____

_____

Student's Signature: _____ Date: _____

IF A PERMANENT INCOMPLETE IS GRANTED, THE NOTATION 'AUTHORIZED ABSENCE' WILL APPEAR ON YOUR TRANSCRIPT FOR ALL THE APPROVED COURSES.

FOR OFFICE USE ONLY

- ☐ **Permanent Incomplete for all the above courses** ☐ **2x** ☐ **AH**
- ☐ **Permanent Incomplete granted for courses marked with Registrar's initials** ☐ **DR** ☐ **AA**
- ☐ **Permanent Incomplete denied** ☐ **3x**

Registrar's Signature: _____ Date: _____

MEDICAL REPORT

Patient's Name: _____ Date: _____

This is to certify that the above-named patient was seen on the following date(s):

_____ _____ _____
_____ _____ _____

and will be unable to attend school: ☐ completely

☐ partially - Details: _____

_____
_____
_____

from _____ to _____ as a result of the

following diagnosis:

_____
_____
_____
_____

He/She may resume regular studies as of: _____.

Notes:

_____
_____
_____
_____
_____
_____

_____
Doctor's Name

_____
Doctor's Signature

Address: _____
_____
_____

Telephone: _____