INDIANA UNIVERSITY

Fee Appeal Documentation for Complete Withdrawal/Reduced Course Load Due to Illness or Medical Condition

FORM MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL NOT BE ACCEPTED

STUDENT COMPLETES THIS SECTION	
IU Campus	
Student Name	
Student University ID Number	
Semester and Year	*Circle one* **Fall / Spring / Summer / Winter** of Year_____
Student Signature	_____ By signing, you grant permission to IU's Bursar Offices to contact your medical provider to verify the authenticity of this form.
MEDICAL PROVIDER COMPLETES THIS SECTION (must be a U.S. licensed medical/mental health provider)	
I Recommend(ed) Due to illness or medical condition *(please check only one)*	☐ Reduced Course Load How many classes is the student recommended to take? _____ ☐ Complete Withdrawal
Dates of Treatment	
Medical Provider Signature	By signing, you grant permission to IU's Bursar Offices to contact your office to verify the authenticity of this form. _____ Date _____
Medical Provider Printed Name	
Medical Provider Title	
Medical Provider Phone Number	
Medical Provider Address	
Additional comments, if needed	