



REQUEST FOR WITHDRAWAL FOR MEDICAL OR COMPASSIONATE REASONS

Students may apply for consideration of a Medical or Compassionate exemption using this form and forwarding it to Enrolment Services at: esc@selkirk.ca. Please see [Policy 8616](#) for more information. Results of this request will be communicated to the student by email. **Form MUST be filled out using Adobe Acrobat. Do not use Apple Preview.**

STUDENT INFORMATION

Date: _____

Legal First Name: _____

Legal Last Name: _____

Mailing Address: _____

Email Address: _____

Phone: _____

SELKIRK COLLEGE STUDENT ID

THIS INFORMATION IS CORRECT.

STUDENT SIGNATURE

STUDENT LOAN:

YES

NO

SPONSORED STUDENT:

YES

NO

PLEASE ENTER YOUR PROGRAM AND COURSE INFORMATION BELOW

Program	Semester
Course Number	Section Number

This withdrawal is for:

courses above only

course and program withdrawal

Dropping or changing courses may affect completion of programs or transfer to a university. Students may want to consult a college counsellor before withdrawing. Students receiving financial aid such as student loans or other forms of financial assistance are advised to speak to a Financial Aid Officer before withdrawing from courses. Students who are sponsored should also connect with their sponsor directly.

All refunds associated with a medical/compassionate exemption are subject to policy. Please review [Policy 8616](#) for more information.

OFFICE USE ONLY. REGISTRAR'S OFFICE: AUTHORIZATION FOR REFUND

Late withdrawal granted

Late withdrawal denied

COMMENTS:

REGISTRAR'S OFFICE SIGNATURE

DATE



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ATTENDING PROFESSIONAL

This student has been under my care from _____ to _____. In my opinion this student has medical and/or compassionate reasons which have, or will severely inhibit his/her ability to successfully complete the course(s) noted above. I recommend the student withdraw from the above noted course(s).

PROFESSIONAL CAPACITY (PLEASE STATE):



Affix company stamp or business card

*Some examples of professional capacity held by persons deemed appropriate to sign this form are as follows:
Physician, Lawyer, Physiotherapist, Counselor, Psychologist, and Psychiatrist*

PROFESSIONAL NAME

PROFESSIONAL SIGNATURE

DATE

PHONE

REASON FOR COMPASSIONATE WITHDRAWAL

DEAN/SCHOOL CHAIR: RECOMMENDATION FOR WITHDRAWAL (IF REQUIRED)

Late withdrawal recommended Late withdrawal not recommended

COMMENTS:

DEAN/SCHOOL CHAIR NAME

DEAN/SCHOOL CHAIR SIGNATURE

DATE