## University of California, Berkeley Medical Withdrawal Committee

## Medical/Health Clearance Application

Upon completion, please submit form to: University Health Services, Social Services Unit, 2222 Bancroft Way, room 2280, Berkeley, CA 94720. Form can be faxed to our confidential fax machine at 510-643-0211.

Semester and year you would like to return:					20	☐ Spring 20			☐ Summer 20		
UC Berkeley SID	):	rth Date	e: (mm/dd/yy)				_ Sex:				
Name:	Last: Fire			rst:				Middle:			
Former Name:	Last:			First:				Middle:			
Email: Cur			Currer	rrent Phone:			Alt	Alternate Phone:			
Current Mailing Address: Street:					City:					Zip:	
Semester/Year y	ou withdrew:	☐ Fall		Spring	Year _						
Have you filed an Application for Readmission with the Registrar's Office?   Yes  No											
If yes, for which semester? :   Fall  Spring  Year											
School/College Enrolled at Berkeley:											
☐ Undergraduate ☐ Grad				duate De			partment:				
Have you completed any course work at Berkeley or another institution while on leave?  Yes  No If yes, please submit a copy of your transcript with this request.  Please comment on what has changed since you withdrew from UC Berkeley, and why you feel sufficiently recovered to resume your studies. Please limit your statement to the space provided.											
Signature:					Date:						