



INSTRUCTIONS	
<p>Students who have medical or extenuating personal circumstances may apply for consideration of a retroactive withdrawal. Retroactive withdrawal requests must be submitted within 12 weeks of the completion of the term. To submit an application please complete the following steps:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete Part 1 and attach a personal statement. <input type="checkbox"/> Have an appropriate professional complete and sign Part 2 and/or attach any supporting documentation. <input type="checkbox"/> Submit completed application for Retroactive Withdrawal Form to: <ul style="list-style-type: none"> o The Pas Campus - Enrolment Services Office o Thompson Campus - Student Services Office <p><i>Note: Completion of this application form does not guarantee that your request will be granted.</i></p>	

PART 1 – STUDENT

PERSONAL INFORMATION				
LEGAL FAMILY NAME		LEGAL FIRST NAME (MIDDLE INITIAL)		STUDENT NUMBER
PERMANENT ADDRESS			TOWN/CITY	PROVINCE
POSTAL CODE	HOME PHONE NUMBER	CELL PHONE NUMBER	TERM	
PROGRAM OF STUDY				
SIGNATURE			DATE (MM/DD/YYYY)	

REQUESTED COURSES
<input type="checkbox"/> I am applying to be withdrawn from all registered courses for the term indicated above.
<input type="checkbox"/> I am applying for a partial withdrawal for the term indicated above. Courses are listed below.
<p><i>Note: If you are choosing this option please provide an explanation in your personal statement indicating why only certain courses have been affected.</i></p>

SUBJECT	NUMBER	SECTION	COURSE NAME

<p>PERSONAL STATEMENT: Please attach a personal statement detailing your reasons for submitting an application for a medical/personal withdrawal. Your statement must include a date and signature and preferably be typed. If you have any questions about the collection and use of this information please contact the Registrar, University College of the North at 204-627-8545.</p>
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PART 2 – PROFESSIONAL ASSESSMENT

ATTENDING PROFESSIONAL	
Student Name: _____	
This student has been under my care from _____ to _____ <div style="display: flex; justify-content: space-around; font-size: small;"> (MM/DD/YYYY) (MM/DD/YYYY) </div>	
<input style="width: 40px; height: 20px;" type="checkbox"/> <small>Initials</small>	In my opinion, this student has had or continues to experience medical and/or extenuating personal circumstances which have, or will severely inhibit his/her ability to successfully complete the course(s) noted in Part 1 of this form.
PROFESSIONAL CAPACITY (For example, Physician, Lawyer, Physiotherapist, Counsellor, Nurse Practitioner, Midwife etc.)	
NAME	PHONE NUMBER
SIGNATURE	DATE (MM/DD/YYYY)
Please provide a company stamp or attach business card here.	
<div style="border: 1px solid black; width: 80%; margin: auto; min-height: 100%;"></div>	

OFFICE USE ONLY

DECISION	
<input style="width: 30px; height: 20px;" type="checkbox"/> Approved <input style="width: 30px; height: 20px;" type="checkbox"/> Denied	Comments: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
AUTHORIZED SIGNATURE	DATE (MM/DD/YYYY)