EXTENUATING WITHDRAWAL APPLICATION

Registrar's Office, Birch Building, room BR230, 2055 Purcell Way, North Vancouver, B.C. V7J 3H5
Email: extenuatingwithdrawal@capilanou.ca

PLEASE READ CAREFULLY

Withdrawal from courses after the end of the withdrawal period is only granted for extenuating circumstances, which are often related to a medical situation.

To submit an application:

- Complete Part 1, 2, 4 and attach a **personal statement.**
- Have an appropriate professional fill out and sign Part 4 and attach any additional documents.
- Submit completed application to email listed above.

Please note:

1. You are encouraged to consult with your instructors to identify alternatives for successful completion of your course(s) prior to applying for an extenuating withdrawal.
2. Completion and submission of this application form does not guarantee that your request will be granted.
3. If able, you should continue to attend classes and complete course requirements while your application is reviewed.
4. If you are receiving financial aid in the form of a loan, scholarship, award, or bursary, it is strongly recommended that you contact Financial Aid & Awards to determine if your current or future financial aid will be impacted.

PERSONAL INFORMATION - PART 1

LEGAL LAST NAME	LEGAL FIRST NAME	STUDENT NUMBER
HOME PHONE NUMBER	**CELL PHONE NUMBER**	**TERM OF REQUEST**
PROGRAM OF STUDY		
SIGNATURE	**DATE (MM/DD/YYYY)**	

REQUESTED COURSES – PART 2

☐ I am applying to be withdrawn from all registered courses for the term indicated above.

☐ I am applying to be withdrawn only from specific course(s) indicated below.*

**Note: If you are choosing this option please provide an explanation in your personal statement indicating why only certain courses have been affected.*

SUBJECT	NUMBER	SECTION	COURSE NAME

PERSONAL STATEMENT – PART 3

Please attach a **personal statement** detailing your reasons for submitting an application for an extenuating withdrawal. Your statement should be typed and must include a **date** and a **signature**.

PROFESSIONAL ASSESSMENT – PART 4

Student Name: _____

This student has been under my care from _____ to _____
(MM/DD/YYYY) (MM/DD/YYYY)

Please explain why, in your opinion, this student has medical or compassionate circumstances which have, or will, severely inhibit his or her ability to successfully complete the course(s) noted in Part 1 of this form:

PROFESSIONAL CAPACITY (E.G. PHYSICIAN, LAWYER, PHYSIOTHERAPIST, COUNSELLOR, PSYCHOLOGIST, AND PSYCHIATRIST)	
NAME	PHONE NUMBER
SIGNATURE	DATE (MM/DD/YYYY)

Apply company stamp or attach business card:

REGISTRAR'S OFFICE USE ONLY

REGISTRAR'S OFFICE: AUTHORIZATION

	Comments:
☐ GRANTED ☐ DENIED	
REGISTRAR'S SIGNATURE	DATE (MM/DD/YYYY)