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:	☐ Fall 20_____	☐ Spring 20_____	☐ Summer 20_____	
UC Berkeley SID: _____	Birth Date: (mm/dd/yy) _____-_____-_____	Sex: ☐ M ☐ F		
Name:	Last:	First:	Middle:	
Former Name:	Last:	First:	Middle:	
Email:	Current Phone:	Alternate Phone:		
Current Mailing Address:	Street:	City:	State:	Zip:
Semester/Year you 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	☐ Graduate	Department:		
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: _____