Medical Leave Form
Must be Submitted with Graduate Student Leave Form

Student Name_____________________________________
WSU ID#__________________________________________

________________________________________________________________________

This section to be completed by student’s health care provider only

I am recommending that ____________________________be allowed medical leave of absence beginning
(MM/DD/YY) ____________________ and ending (MM/DD/YY) ____________________

Date Condition began:__________________     ___Date Unknown

Signature of Health Care Provider______________________________________________

Address of Health Care Provider_______________________________________________

Submit this form to:

Graduate School
324 French Administration Building
PO Box 641030
Pullman, WA 99164-1030
509-335-6424
509-335-1949 Fax
Gradschool.wsu.edu

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