



Graduate School

WASHINGTON STATE UNIVERSITY

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