University of California, Berkeley
Medical Withdrawal Committee

Request for Medical Clearance for Readmission Application

Upon completion, please mail the form to: University Health Services, Social Services Unit, 2222 Bancroft Way, room 2280, Berkeley, CA 94720, phone 510-642-6074. You can fax the form to our confidential fax machine at 510-643-0211.

Semester and year you would like to return:	☐ **Fall 20_____**	☐ **Spring 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.

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Signature:_____ Date:_____