Med College

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Leave of Absence Request

I request a leave of absence from Med Academy

Beginning _____ I will return to school on _____

For the following reasons: _____

I understand the regulations require that:

I am allowed to request a leave of absence for a period of one semester.
The total of all my leave of absence may not exceed 180 days in a 12-month period.
I will not incur any additional tuition charges during any leave of absence.
When the period for leave of absence ends, I must go to Registrar's Office to either receive my schedule to continue classes or withdraw from school.
In event I do not return from a leave of absence, I will be dropped from the school and any refunds due will be made to the appropriate financial aid programs within 30 days of the date I was scheduled to return.
If a credit balance occurs in the event, I do not return from a leave of absence I am requesting that any excess funds are ____ returned to me, or ____ to the appropriate source.

_____ _____ _____

Student Name (print full name) Student Signature Date

INSTITUTIONAL USE ONLY

This leave of absence is approved

Notes:

_____ _____/ ____ / ____
Registrar Date

_____ ____ / ____ / ____
Financial Aid Coordinator Date

_____ _____ / ____ / ____
Program Director Date