Med Academy

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Leave of Absence Request

I request a leave of absence from Med Academy

Beginning (mm/dd/yy) ____ / ____ / ____ for the following reason:

_____

_____

I will return to school on (mm/dd/yy) ____ / ____ / ____

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 have to 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 schedule 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 last name, first name)

_____ ____ / ____ / ____
Student Signature Date

INSTITUTIONAL USE ONLY

This leave of absence is approved

_____ ____ / ____ / ____
Registrar Date

_____ ____ / ____ / ____
Financial Aid Coordinator Date

_____ ____ / ____ / ____
Program Director Date

Remarks: