Center for Allied Health Education
LEAVE OF ABSENCE FORM
A letter with the reason for request must be attached

TO BE COMPLETED BY STUDENT:

Please check the appropriate semester:
☐ Junior ☐ Senior ☐ One Year Program

Type of Leave: (supporting documentation may be required)

☐ Medical: _____ ☐ Maternity

☐ Other: _____

Program: _____ Student ID Number: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home (_____) _____ Work (_____) _____

Cell (_____) _____ Other (_____) _____

Email: _____ SS #: _____-_____-_____

Estimated start date for the leave: _____ **Estimated return date from leave:** _____

I certify that the information given in this leave of absence request is complete and accurate. I am aware that if I don't return from my leave of absence on the date approved, I will automatically be withdrawn from the New York Methodist Hospital Center for Allied Health Education. Such a withdrawal may affect my financial aid status and I take full responsibility for any financial obligations that may result from my withdrawal.

Student: _____
Print Name Signature Date

Is student in good academic standing? ☐ Yes ☐ No

Program Director: _____
Print Name Signature Date

Student received financial aid? ☐ Yes ☐ No If yes, what percent of the program has the student completed? _____

Director of Financial Aid: _____
Signature Date

Is student's financial account up to date? ☐ Yes ☐ No

Director of Financial Services: _____
Print Name Signature Date

Recommendation for Approval: ☐ Yes ☐ No Dates for approval: _____ to _____

Assistant Director: _____
Print Name Signature Date

Leave of Absence Approved: ☐ Yes ☐ No Dates approved: _____ to _____

Director: _____
Print Name Signature Date

*** If LOA is granted, a learning contract must be generated**

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