



EASTERN VIRGINIA
MEDICAL SCHOOL

EASTERN VIRGINIA MEDICAL SCHOOL Leave of Absence Notification Form

Full Name _____ SID# _____

Date _____

A leave of absence is requested for the following reason:

- _____ Academic
- _____ Financial
- _____ Health
- _____ Other Reasons

The leave of absence will be from _____ to _____

I understand that if I fail to return to EVMS at the end of the approved leave of absence, (a leave of absence cannot exceed 180 days for any 12 month period), I will be considered withdrawn as of the start date of my leave of absence for financial aid purposes. I also, understand that the repayment terms mandated on my promissory note(s) will take effect, including the exhaustion of some or all of my grace period if I do not return.

Signed

Date

The requested leave of absence has been approved:

disapproved:

Program Director, Health Professions

Date

The requested leave of absence has been approved:

Associate Dean for Academic Affairs

Date

NOTIFICATION RECEIVED BY:

Registrar _____

Date _____

Financial Aid Office _____

Date _____

Accounts Receivable _____

Date _____

NOTE: This form MUST be SIGNED AND DATED by the Associate Dean for Academic Affairs for a leave of absence to be approved.