ROLLINS SCHOOL OF PUBLIC HEALTH
Office of Student Services

LEAVE OF ABSENCE REQUEST

Student Name: ____ ID Number__________________

Department: ____

____
Street City State Zip Code

____
Daytime Phone

Period of Requested Absence: From ______________________ ___________
Semester Year

To ______________________ ___________
Semester Year

Reason for Leave of Absence

______ Personal ______ Job Related ______ Financial ______ Other

Please Explain (attach additional sheet if necessary):

____

I plan to enroll again during _________________ _________________
Semester Year

My anticipated graduation date is ______________ _________________
Semester Year

I will contact the Rollins School of Public Health **at least 30 days prior to my re-enrollment and complete a re-admission form.**

____ ____________________
Student Signature Date

Students on an approved leave of absence will **not** have that time counted toward the five year limit to complete the degree.

____ ____________________
ADAP Signature Date

Please check the appropriate box: **Approval** **Disapproval**

Student Services Use

Processed by ____
Name Date

With department approval, an email may be attached in lieu of electronic or physical signatures.

Revised 10/2017