



## REQUEST FOR LEAVE OF ABSENCE FROM GRADUATE STUDIES

FIRST NAME

LAST NAME

STUDENT ID # (SEVEN DIGITS)  NETID  PHONE

EMAIL

Do you have a graduate assistantship  Yes  No

Period of requested leave of absence \_\_\_\_\_ to \_\_\_\_\_  
Start End

*\*period cannot extend beyond 12 months from date of request*

### REASON FOR LEAVE OF ABSENCE

Reason: <input type="checkbox"/> Personal <input type="checkbox"/> Medical
Describe:

*\*By signing below, you affirm that the student will be allowed to return once qualifications for return have been verified by The Graduate School*

### REQUIRED SIGNATURES

MAJOR ADVISOR	ACTION	COMMENTS
Print Name: _____	<input type="checkbox"/> Approve	
Signature: _____	<input type="checkbox"/> Disapprove	

DEPARTMENT OR PROGRAM HEAD	ACTION	COMMENTS
Print Name: _____	<input type="checkbox"/> Approve	
Signature: _____	<input type="checkbox"/> Disapprove	

### ACTION BY GRADUATE SCHOOL:

PERSON REVIEWING	DATE	ACTION TAKEN
Print Name: _____		<input type="checkbox"/> Approve
Signature: _____		<input type="checkbox"/> Disapprove

*Note that requests for medical leave of absence must be accompanied by documentation from an appropriate health care provider.*