



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 and dates must be specific (mm/dd/yyyy format).*

REASON FOR LEAVE OF ABSENCE

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