HEALTH CAREER COLLEGE

NAME: Last Name First Name Middle Initial

Application For Planned Educational Leave

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Home Phone: ( ) _____ Social Security Number: _____

Cell Phone: ( ) _____ Email Address: _____

Program: Term & year:

Return Term: _____ _____

My reasons for this request are: *(Please specify clearly and attach supporting documentation)*

I understand that an approved Leave of Absence does not release me from any financial obligation owed for fees,

_____

_____

_____

_____

_____

_____

_____

_____

_____

tuition or financial aid.

Student Signature: _____ Date:

School Director _____

☐ Approve

☐ Deny

Signature: _____