HEALTH CAREER COLLEGE

NAME: Last Name First Name Middle Initial

PETITION FOR WITHDRAWAL FROM HEALTH CAREER COLLEGE

An approved withdrawal will show as a grade of "W" on transcripts, future class lists, and posted grades. Attach relevant supporting documentation to this form. If more space is needed, attach another sheet.

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: _____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand that an approved withdrawal does not release me from any financial obligation owed for fees, tuition or financial aid.

Student Signature: _____

School Director

☐ Approve

☐ Deny

Signature _____