United Medical Institute
5280 Auburn Blvd., Sacramento, CA 95841
Ph: (916) 334-5118, Fax: (916) 334-6852
Web: http://www.unitedmedicalinstitute.com/

LEAVE OF ABSENCE REQUEST FORM

Student Full Name: _____ Date: _____
Please print your Last Name, First Name

IMPORTANT:
Please make sure to read the Leave of Absence Policy available on the website and School Catalog prior to competing and submitting the Leave of Absence Form.

Last Day Attendance: _____ Expected Return Date: _____

Contact Information during the leave of absence:

Address: _____

Phone Number: _____ Email Address: _____

Reasons for Leave *(State your reason for requesting this leave)*

I am taking a Leave of Absence from United Medical Institute for the reasons stated above. I have read, understood and agree to Leave of Absence policy of UMI. I understand that the Leave of Absence I am taking may cause a delay and/or affect my internship placement. If I fail to attend my classes by the return date printed above, appropriate actions will be taken. My signature below signifies I read and agree with the policies as outline on this form.

Student Signature: _____ Date: _____