The University of Toledo - College of Medicine
Return from Leave Form

Name: ____ **Class year:** _______________

Address: ____

City: _________________ **State:** __________ **Zip:** ___________

Telephone: ( ) _________________________ **Pager:** ( ) ________________________

LOA Validation Date: ____________________ **Return Date:** ________________________

Reason for Request: ____

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If granted a Medical Leave of Absence, a signed and dated statement from your physician releasing you to return to school must accompany this form.

Additional comments:____

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Course directors to notify:____

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Please provide a brief description of the circumstances that allow you to return to medical student status:____

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_______________________________ _________________________

Student Signature Date

Recommended: _________________________________ _________________________

Associate Dean for Student Affairs Date

Approved: _____________________________________ _________________________

Dean, College of Medicine Date

ORIGINAL Registrar
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