



# LEAVE OF ABSENCE REQUEST College of Nursing

Main Campus MS 119  
Health Sciences Human Services Bldg  
2801 West Bancroft  
Toledo, Ohio 43606-3390  
419.530.2673

Health Science Campus MS1026  
Collier Building 4430  
3000 Arlington Avenue  
Toledo, OH 43614-2598  
419.383.5859

This form is used to obtain approval for a Leave of Absence from the College of Nursing and applies when the student is:

- currently registered and dropping all courses prior to completion of the present semester.
- currently registered and completing the semester, but will not return next semester.
- not currently registered, but was enrolled in the program last semester.

This form does not apply to persons offered a seat in a program, but who do not start nursing courses on the effective matriculation date. These individuals must reapply and meet standards in place at the time of reapplication, acceptance and matriculation.

Name	Student ID
Forwarding Address	Phone
Email	Last day attended class:

Reason:

- Illness
- Hospitalization
- Maternity
- Family Obligations
- Military
- Personal
- Financial
- Other \_\_\_\_\_

When will you return to program? \_\_\_\_\_

If currently enrolled, are you completing the semester?       Yes     No

If you will be attending another school, which one? \_\_\_\_\_ #credits \_\_\_\_\_

- I understand this form is used by the College of Nursing to retain my seat in the nursing program.
- I understand this form does not guarantee registration in any theory or clinical course.
- I understand that a leave of absence cannot extend more than twelve calendar months.
- I understand a Plan of Study must be submitted to the College of Nursing **at least eight weeks** before the official start date of the semester in which return to class and/or clinical is planned.
- I understand the nursing advisor is consulted to develop an official Plan of Study.
- I understand it is my responsibility to work with the Registrars Office to withdraw from courses.
- I understand it is my responsibility to work with the Bursars Office to settle outstanding accounts.
- I understand it is my responsibility to know university and federal guidelines/deadlines apply and to take action accordingly.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

Received in appropriate College of Nursing program office Date: \_\_\_\_\_

Associate Dean signature: \_\_\_\_\_ Date: \_\_\_\_\_

*NOTE: Original signed form must be provided; fax or electronic submittal is not acceptable.*