WITHDRAW FROM NURSING COURSE
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 4424
3000 Arlington Avenue
Toledo, OH 43614-2598
419.383.5859

This form notifies the College of Nursing that the student is withdrawing from the following nursing courses:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Name ____________________________ Student ID _______________________

Forwarding Address ____________________________ Phone _______________________

Email ____________________________ Last day attended class: ________________

Reason: ☐ Illness ☐ Hospitalization ☐ Maternity
☐ Family Obligations ☐ Military ☐ Personal
☐ Financial ☐ Other ____________________________

☐ I understand that withdrawing from nursing courses requires reapplication to the nursing program.
☐ I understand that I may be readmitted only one time after a withdrawal.
☐ I understand that a course failure and a course withdraw make me ineligible for readmission.
☐ I understand that I must comply with existing university requirements at the time of readmission.
☐ I understand that I must comply with existing CON requirements at the time of readmission.
☐ I understand that absence of one academic year may require auditing previously passed nursing courses and satisfactory performance of skills to assure current clinical competency.

☐ I understand it is my responsibility to work with the nursing advisor to withdraw from the program.
☐ 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: ______________

Advisor 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. FORM 5/09