School of Medicine
Department of Student Affairs and Records

Request for Withdrawal From the School of Medicine

(to be used only if you are permanently withdrawing from the School of Medicine)

Please return completed form to Ms. Sarah Berry in the Office of Student Affairs (sberr4@lsuhsc.edu).

Student Name: ______________________________________ **Student ID:** ____________________________

Graduation Year: __________________________ **Last day you attended class:** _______________________

Current Address/Phone/Email: ____

Withdrawal from School/Program: Refer to the Withdrawal Policy for more information.

Please check reason: Academic ☐ Medical ☐ Personal ☐ Financial ☐
Other ☐ ____

If you are currently enrolled, are you completing the academic term? Yes ☐ No ☐

Are you permanently withdrawing from your academic program? Yes ☐ No ☐

I have considered all academic and financial ramifications of my request, effective on the date I have requested.

Student's Signature: ____ Date: _______________

FOR OFFICE USE ONLY:

☐ **Hold** – Pending the following: ____

☐ **Denied** – Reason(s): ____

☐ **Approved** ____ Date: ____________________
Signature of Associate Dean of Student Affairs

Effective date: _______________________