LSU Health NEW ORLEANS

School of Medicine
Department of Student Affairs and Records

Request for Withdrawal From the School of Medicine

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

Please return completed form to Mr. Jon Kulick in the Office of Student Affairs (jkulic@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 ☐

Do you plan to petition for readmission in the future? Yes ☐ No ☐

I am aware there could be academic and financial ramifications due to my request.

Student's Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Deans Signature: _____ Date: _____