NELL HODGSON WOODRUFF SCHOOL OF NURSING
Office of Enrollment and Student Affairs

REQUEST FOR LEAVE OF ABSENCE

(Please print in blue or black ink)

Return completed form to: Student Services, Nell Hodgson Woodruff School of Nursing, 1520 Clifton Road, NE, Atlanta, GA 30322, or fax to: 404-727-8509.

Student Name_____ ID Number_____ Department_____

_____
Street City State Zip Code

_____ _____ _____
Daytime Phone Alternate Number Email Address

Period of Requested Absence: From: _____ _____
Semester Year

To: _____ _____
Semester Year

Reason for Leave of Absence:
_____Personal _____Job Related _____Financial _____Other _____ Medical*****

****Please note that when you return from medical leave you must provide written clearance from your treating physician***

Please Explain (attach additional sheet if necessary) _____

_____

I plan to return**: _____ _____ **Anticipated graduate date is**: _____ _____
Semester Year Semester Year

****Please note that your ability to return is based upon space and clinical program availability and program director approval and is not guaranteed.**

I will contact the School of Nursing **at least 60 days prior to my re-enrollment and complete a re-admission form.**

Signature_____ Date_____

Associate Dean for Undergraduate Education or MSN or DNP Program Director

_____
Signature Date

Office of Enrollment and Student Affairs Designee

_____
Signature
Date
The time on approved leave of absence will __ will not __ count toward the five year limit to complete the degree.

Student Services Use Only

Processed by _____
Name Date

Revised 11/8/2017