

Saint Francis Medical Center College of Nursing
Peoria, Illinois



COLLEGE LEAVE OF ABSENCE FORM

I, _____, will be taking a leave of absence from Saint
(Student Name)
Francis Medical Center College of Nursing, effective _____.
(Semester/Year)

I understand that a leave of absence may be taken for up to one year. My projected
semester of return is _____.
(Semester/Year)

I understand I am responsible for all my financial obligations to the College of
Nursing and understand the stated refund policy.

I understand, upon my return, I will be enrolled in courses based on the Course
Placement Policy and may not be able to resume taking classes immediately.

I understand I must be in good academic standing to be considered for approval for
a leave of absence.

I understand I will pay tuition and fees at the rates in effect at the time of
reenrollment and that fees submitted for one semester are not transferable to
another semester.

Reason for leave of absence (check only one)

Personal Medical Other (please explain)
 Financial Military

____ Interview with Dean

Date

Student Signature

Date

Advisor

Date

Dean

Date

Student Finance Office

Date

Registrar

Date