

**TO BE COMPLETED BY STUDENT:** Complete as appropriate, sign, and submit to your area Dean of Students

Name: \_\_\_\_\_ UCID: \_\_\_\_\_ Department: \_\_\_\_\_  
 (Last) (First)

Current Address: \_\_\_\_\_  
 (Street) (Apt.) (City) (State) (Zip) (Country)

Address while on Leave: \_\_\_\_\_  
 (Street) (Apt.) (City) (State) (Zip) (Country)

Tel No. while on Leave: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Reason(s): Please explain the reason(s) for the requested leave. Use the back of this page if necessary. **Attach** a copy of a letter from a physician/psychiatrist confirming the need for the requested leave and expected duration of leave.

Effective date: \_\_\_\_\_ Quarter of expected return\*: \_\_\_\_\_  
 (quarter/yr) (quarter/yr)

Are you currently enrolled in U-SHIP (student health insurance)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, do you wish to remain on U-SHIP through the current plan year (Aug 31<sup>st</sup>)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please NOTE:

1) Your U-SHIP coverage will continue through the current plan year (August 31<sup>st</sup>). To purchase continuation insurance coverage for subsequent quarters of medical leave, please contact the United Healthcare/Student Resources on-campus representative in Administration Building, Room 231/232.

2) While on U-SHIP, you will be assessed the University Health and Wellness Fee each quarter (summer optional) unless you live 100+ miles from campus during your leave. Payment of the fee allows access to SCC and SCRS.

**International Students Please Note:** Immigration regulations require continuous enrollment on a full-time basis. Therefore, please consult with Office of International Affairs before taking a Leave of Absence.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (your signature indicates you have read the above information) (mo/day/yr)

\* **Note: Leave of Absence for childbirth cannot exceed one quarter**

**TO BE COMPLETED BY AREA DEAN OF STUDENTS: Medical Leave of Absence Decision**

(Note: PhD students in Advanced Residence must have approval for a medical leave of absence from the Deputy Provost. Once obtained, the area DOS should complete below.)

\_\_\_ Granted for the period: \_\_\_\_\_ to \_\_\_\_\_  
 (mo/yr) (mo/yr)

\_\_\_ Denied for the following reason:

DOS Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If approved, DOS please forward a copy of this application to JoAnn Creviston (Registrar's Office) **and** Celia Bergman (VPDoS) Health Affairs.