

# The University of Chicago **Medical Leave of Absence Application**

**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)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please NOTE:

- 1) Your U-SHIP coverage will continue through the current plan year (August 31). To purchase continuation insurance coverage for subsequent quarters of medical leave, please contact the United HealthCare Student Insurance representative on campus 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 leave 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)

**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).*