OFFICE OF STUDENT ASSISTANCE

MEDICAL LEAVE OF ABSENCE APPLICATION

STUDENT ID NUMBER | LAST NAME | FIRST NAME | MIDDLE

STREET ADDRESS/P.O. BOX | CITY | STATE | ZIP

DAY TELEPHONE NUMBER | EVENING TELEPHONE NUMBER | MOBILE/CELL NUMBER | E-MAIL ADDRESS

In order to apply for a medical leave of absence, a student must complete a Medical Leave of Absence Application, a Consent for Communication Regarding a Request for Medical Leave of Absence and/or Resumption of Studies after a Medical Leave of Absence, and an Authorization for Information Release. The completed documents must be submitted to the University Registrar, Office of Student Assistance, One Pace Plaza, New York, NY 10038.
Please see the University's Medical Leave of Absence Policy for more information.

Semester the **Medical Leave of Absence** is to be effective:

- ☐ FALL (70) YR 20_____
- ☐ SPRING (20) YR 20_____

Semester the **Resumption of Studies** will occur:

- ☐ FALL (70) YR 20_____
- ☐ SPRING (20) YR 20_____

I am currently enrolled as follows:

LEVEL:
- ☐ 01 (Undergraduate)
- ☐ 02 (Graduate)
- ☐ 05 (Doctoral)

HOME CAMPUS:
- ☐ 1 (New York City)
- ☐ 2 (Pleasantville)
- ☐ 3 (White Plains)

DEGREE: _____

MAJOR: _____

- ☐ Full-time
- ☐ Part-time
- ☐ Day
- ☐ Evening

Along with this application, I have completed and attached the following forms:

- ☐ CONSENT FOR COMMUNICATION REGARDING REQUEST FOR MEDICAL LEAVE OF ABSENCE AND/OR RESUMPTION OF STUDIES AFTER A MEDICAL LEAVE OF ABSENCE
- ☐ AUTHORIZATION FOR INFORMATION RELEASE FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have read and understand the University's Medical Leave of Absence Policy.

_____

Student's Signature **Date**

THE FOLLOWING IS TO BE COMPLETED BY THE UNIVERSITY REGISTRAR

Verification of Documentation:

- ☐ CONSENT FOR COMMUNICATION REGARDING REQUEST FOR MEDICAL LEAVE OF ABSENCE AND/OR RESUMPTION OF STUDIES AFTER A MEDICAL LEAVE OF ABSENCE
- ☐ AUTHORIZATION FOR INFORMATION RELEASE FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Sent:

- ☐ TREATING HEALTHCARE PROVIDER'S STATEMENT FOR MEDICAL LEAVE OF ABSENCE

Verification Received From:

- ☐ University Health Care ☐ NYC ☐ PLV Date _____
- ☐ Counseling Center ☐ NYC ☐ PLV Date _____

Sent to: ☐ Academic Advisor ☐ Chairperson ☐ Assistant or Associate Dean

CREATED 08/12

ACADEMIC APPROVAL

_____

Academic Advisor/Chair/Associate or Assistant Dean (Print) Office Phone Number

_____

Signature of School/College Official Date

FOR OFFICE OF STUDENT ASSISTANCE USE ONLY

☐ WITHDRAWN FROM CURRENT SEMESTER AND/OR DROP FROM FUTURE SEMESTER

☐ NOTIFIED TUITION APPEAL ABOUT POTENTIAL MEDICAL CANCELLATION

☐ CREATE NEW SGASTDN RECORD

☐ UPDATE STUDENT STATUS

☐ UPDATE CURRICULA TAB (then SAVE)

☐ NOTIFIED CAMPUS DIRECTOR/ASSOCIATE DIRECTOR OF FINANCIAL AID BY EMAIL (IF PACE MERIT BASED AID RECEIVED)

☐ SENT APPROVAL LETTER

☐ SENT CONSENT FOR COMMUNICATIONS

☐ SENT AUTHORIZATION FOR INFORMATION RELEASE

☐ SENT RESUMPTION OF STUDIES AFTER A MEDICAL LEAVE OF ABSENCE APPLICATION

☐ SCAN INTO BDMS AND FILE ORIGINAL

☐ PROCESSED BY _____ DATE _____

OSA REPRESENTATIVE