**Student Name:** _____     **Student ID**: _____

**Contact Information:** (where you can be reached following program withdrawal)
Address:                                                    Phone number:
                                                           Cell phone number:
                                                           Email address:

**Program:**                                               **Reason for withdrawal:**

☐MS Anesthesia                                             ☐Academic difficulty

☐MMS Physician Assistant                                   ☐Medical Condition

☐MS Bioinformatics                                         ☐Career change (explain)

☐Graduate Certificate Clinical Research                    ☐Other (explain)

☐Other _____

**Plans following withdrawal from UMKC School of Medicine:**

☐Pursue other degree at UMKC (list below)                 ☐No plan to pursue a degree program at this time

☐Pursue other degree program on another UM campus (list below)   ☐Uncertain

☐Pursue other degree program at another university (list below)   ☐Other: (explain)

Name of Degree program pursuing: _____

**Meet with appropriate offices and individuals applicable to your situation:**
1.  The program director or department chair to discuss your decision to withdraw from the program
    *Program Director or Dept Chair signature and date* _____
2.  The degree program assistant or designee to return program issued ID badges, supplies, and other items
    *Program Assistant signature and date* _____
3.  Student Affairs Education Coordinator to discuss your decision to withdraw and the UMKC withdrawal process
    *Education Coordinator signature and date* _____
4.  Other offices (when applicable) to meet with in order to address your situation:
    a.  International Student Affairs Advising Office
    b.  Financial Aid and Scholarships Office
    c.  Veterans' service coordinator in Registration and Records
    d.  Cashier's office to review your account and set up a payment plan.

My signature below confirms my intent to withdraw from the UMKC School of Medicine. I understand it is my responsibility to meet with the School of Medicine Office of Student Affairs Education Coordinator, the Financial Aid Office, the Cashier's Office, the Registrar's Office, and other university offices as necessary. I further understand that counseling is available to me as an active student through the University Counseling Center.

Student Signature: _____Date: _____

Assistant Dean Signature: _____Date: _____

Office of Council on Evaluation Signature: _____Date: _____