UMKC School of Medicine ~ Council on Evaluation
Program Withdrawal Form

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

Contact Information *(where you can be reached following program withdrawal):*

Address _____ Phone Number _____

_____ Cell Phone Number _____

_____ E-mail Address _____

Program Type (check one):

_____ BA/MD _____ OS/MD

_____ MD-Only _____ Advanced Standing/Transfer

Effective date of withdrawal: _____

Reason for withdrawal (check one and provide additional explanation if necessary):

_____ Academic difficulty _____ Career change

_____ Medical condition _____ Other (please explain): _____

_____

_____

Plans following withdrawal from the UMKC School of Medicine (check one and provide additional explanation if necessary):

____ Pursue another degree program at UMKC ____ Not planning to finish a degree program at this time

____ Pursue another degree program on another UM campus ____ Unknown

____ Pursue another degree program at another university entirely ____ Other: _____

_____

_____

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, the Financial Aid Office, the Cashier's Office, the Registrar's Office or other university office as necessary in order to fulfill any outstanding obligations. I further understand that counseling is available to me through the University Counseling Center.

Student Signature: _____ **Date:** _____

Signature of the Associate Dean for Student Affairs or Authorized Designee: _____

Date: _____

Comments: _____

_____

_____

Executive Acceptance of Withdrawal: _____ Accepted _____ Denied

Comments: _____

_____

_____

Signature of the Council Chair or Authorized Designee: _____

Date: _____