Cleveland Clinic

PROGRAM WITHDRAWAL FORM

This form is to be completed by a student planning to withdraw from a Cleveland Clinic Internal Health Professions Program.

Student Name: _____ Date: _____

CCF ID Number: _____

Student Address _____

City: _____ State: _____ Zip: _____

Phone _____

CCF Program: _____

Option #1. I have completed LESS than 75% of the CCF Program identified above.

By signing, I acknowledge withdrawing from this CCF program at this time may have consequences, which include:

- No refund of tuition or other fees.
- A "W" will appear on my transcript.
- Withdrawing from the program in good standing may not guarantee reentering the program at a later date.

NOTE: Before making the final decision to withdraw from the program, it is in your best interest to discuss your academic situation and explore all of your options with your program director.

☐ I have discussed my options with the program director.

☐ I have not discussed my options with the program director and choose not to do so at this time.

Reason for Withdrawing:

_____

I understand that a withdrawing from the program is effective the date this form is processed and my partial refund, if any, will be calculated based on that effective date and in accordance with the published refund schedule. Any forms faxed or sent via email outside business hours, during weekends or holidays will be processed and effective the next business day.

Student Signature: _____ Date:_____

Option #2. I have completed MORE than 75% of the CCF Program identified above.

After completing MORE than or equal to 75% of the program, the program director's signature is required along with written documentation which supports the withdrawal. If there is no supporting documentation or the support is not accepted, the earned letter grade (or unsatisfactory grade) will be recorded on the student's transcript at the time of the withdrawal.

Written Verification of Support: (√ those that apply and attach documentation.)

(√)		(√)	
	Medical		Legal
	Military		Administrative
	Approved		Denied

Program Director Signature	
Name (printed)	
Date	