CMU WITHDRAWAL REQUEST FORM

Caribbean Medical University

Campus: Pater Euwensweg 25, Curacao • Phone: (5999) 461-5668
U.S. Off ce: 5600 N River Road Suite 800 • Des Plaines, Illinois 60018 United States
Phone: (888) 877-4268 • Fax: (302) 397-2092 • Email: students@cmumed.org • Web: http://www.cmumed.org

Please fill out this form to request official withdrawal from Caribbean Medical University or transfer to another medical school. The effective date of the withdrawal for tuition refund purposes is the date, the completed form has been returned to the Dean's Office with the student's signature as well as those signatures required for purposes of clearance, unless attendance at an academically related activity can be documented.

STUDENT INFORMATION

1 Name:
Last Name *First Name* *Middle Name*

2 Student ID Number _ _ _ Current Enrollment: —
As appears on ID card *Program - Semester*

3 Address: ( )
Number and street or rural route *Apt. No.* *Phone Number*

City or Town *State* *Zip Code* *Country*

REQUEST INFORMATION

4 From which semester would you like to drop classes? Spring (January) ☐ Summer (May) ☐ Fall (September) ☐ Year _____

5 Do you currently live in CMU Dormitories? Yes ☐ No ☐

If Yes please provide the last date of occupying the room: / /
MM/DD/YYYY

6 Do you participate in CMU Student Health Insurance Plan? Yes ☐ No ☐

If Yes please provide the last date of intended coverage: / /
MM/DD/YYYY

7 Do you participate in CMU Cell Phone Plan? Yes ☐ No ☐

If Yes please provide the plan discontinuance date: / /
MM/DD/YYYY

8 Select your reason for withdrawal/transfer *(select all that apply)*

☐ Medical/Health ☐ Financial Problems ☐ Family Issues
☐ Academic Quality ☐ Study Environment ☐ School's Deficiencies
☐ Rotations Placement ☐ USMLE Passing Rate ☐ Other _____
If Other Reasons Please Explain

9 Have you ever received Financial Aid through MedLoan Program? Yes ☐ No ☐

REV. 012125

TRANSFER STUDENTS

If you intend to transfer to another school and want your transcript to be sent, please fill out this section.

Please note: An official transcript will be sent from Caribbean Medical University listing all credits earned upon approval of this request. Transcript may not be released if the student has an outstanding financial obligation to the school. Official transcripts are for educational institution purposes only and are printed on high quality stock paper, contain CMU seal, and the signature of a certified school official. Official transcripts are sent directly to the educational institution by first class mail. There is a $50 processing fee for each official transcript.

10 School's Name: _____ School's Code: _____

Name of the Institution

11 Address: _____ ( )

Number and street or rural route *Phone Number*

_____

City or Town *State* *Zip Code* *Country*

INSTRUCTIONS

Caribbean Medical University defines a transfer student as someone who is currently enrolled at the university, who intends to discontinue enrollment and who seeks admission to a medical program in a medical school other than CMU within a period of one year.

- Requests for transfer or withdrawal must be reviewed and approved by the Retention Committee.
- CMU reserves the right to set criteria for withdrawals as outlined in the Student Handbook.
- The student must provide the Retention Committee with a one page account for the reasons of transfer before they can be approved.
- The student may submit any other supporting documentation they feel will help their case.
- The Retention Committee is obligated to notify the student of its decision within 14 days.
- If applicable, tuition and fees refund will be processed within 30 days of the withdrawal/transfer approval.

12 STATEMENT: I am currently enrolled at CMU and I wish to discontinue my enrollment at the university. I have read and agree to the university withdrawal and refund policy. I understand that it is my responsibility to follow up with student services that apply to me, and that I must return my Student ID Card to the Registrar's Office. I fully acknowledge that my official transcripts will only be released upon approval of the Withdrawal Request Form, duly filled, along with a $50 transcript request fee. I understand that I am responsible to pay any outstanding obligations to Caribbean Medical University.

Student's Signature: _____ Date: __ __ / __ __ / __ __ __ __

FOR OFFICE USE ONLY		
Date	**Name**	**Remarks**

REV. 012125