UMass Amherst
Education Abroad Withdrawal Form

Student: Last Name: ____________________________ First Name: ____________________________
Date of Birth: _______________________________ UMass Amherst ID: _______________________________

Home Institution: ______________________________
Program Name: ____________________________ Country: _______________________________
Reason: Personal _____ Medical _____ Financial _____ Academic _____ Other _____
Term Abroad: Fall ______ Spring ______ Summer ______ Academic Year: ______ Calendar Year ________

I elect to withdraw from the above University of Massachusetts Amherst Education Abroad Program and agree to the following:

• I am withdrawing from all my credit courses for the academic period indicated above, and will earn no credit for any work I may have completed.
• I understand that my course registration for any future term at my home institution may be cancelled and I may need to re-apply to return to classes at my home institution.
• I understand that withdrawing may have a financial impact on my student aid at my home institution.
• I understand that withdrawing will affect my student and visa/residence permit status abroad.
• I understand that I will not be covered by the Emergency Medical and Accident Insurance provided by the UMass Amherst International Programs Office after the date of my withdrawal.
• In the case of a medical withdrawal, I authorize my current physician, either abroad or in the U.S., to release information necessary to give a statement concerning my medical condition to the Education Abroad Office at UMass Amherst.

Student Signature: ____________________________ Date: ____________________________
Student Email: ______________________________

If abroad, complete this section:
Host Institution International Office Representative or Program Director:
Last Name: ____________________________ First Name: ____________________________
Date Student Last Attended Class: ____________________________
Signature: ____________________________ Date: ____________________________

If this is a medical withdrawal, complete this section:
Physician's Statement:
An official physician's statement on letterhead must be attached to this form stating the patient's condition and dates of treatment and/or hospitalization with effective dates.

In my professional opinion, the student petitioning for medical withdrawal from a University of Massachusetts Amherst Education Abroad Program cannot complete the current semester of school for the medical reasons I have stated in the attached letter.

Physician's Name (please print): ____________________________
Physician's Signature and date ____________________________

Send form and physician's letter (if applicable) to:
Dr. Kalpen Trivedi
International Programs Office
467 Hills South
University of Massachusetts
111 Thatcher Road.
Amherst, MA 01003-9361
USA

1/24/14