# CALIFORNIA ARTS UNIVERSITY

## LEAVE OF ABSENCE FORM

4100 W. Commonwealth Avenue, #101, Fullerton, CA, 92833
Phone: 213-700-7575 Fax: 714-907-1511 Website: www.cauniv.edu E-mail: info@cauniv.edu

_____

Last Name First Name Middle Date of Birth

_____

Student ID No. Program

_____

Mailing Address City State Zip Code

Phone Number: ( ) _____ Email: _____

**TYPE OF LEAVE OF ABSENCE**

( ) Medical (Doctor's Confirmation Required)
( ) Annual Vacation (Verification Required)
( ) Withdraw
( ) Transfer to (School Name): _____
( ) Other (May require additional documents & verifications) _____

**Leave of Absence Start Date:** _____
**Leave of Absence End Date:** _____

Student Signature: _____ Date: _____

**Medical Leave of Absence: This section MUST be submitted to and completed by your Physician/Doctor/Hospital**

Name of the Physician/Doctor/Hospital: _____

Address: _____

Phone Number: _____ Fax Number: _____

Briefly explain the condition of the student/patient: _____

_____

Duration of medical leave of absence (in weeks): _____

Print Name: _____ Title: _____

U.S. Medical License #: _____ Expiration Date: _____

Signature: _____ Date: _____

**I certify that the student/patient named above is unable to attend class(es) for the reason(s) stated above.**

**All other Leave of Absence: This section must be submitted and completed by the Administration**

Leave of Absence Approved by: _____ Title: _____

Signature: _____ Date: _____