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FLORIDA AGRICULTURAL AND MECHANICAL UNIVERSITY

REGISTRAR'S OFFICE

1700 Lee Hall Drive, 112 Foote-Hilyer Administration Center
Tallahassee, FL 32307-3200
Office: (850) 599-3115 Fax: (850) 561-2428 Email: registrar@famu.edu

Official University Withdrawal Form

This form is to be used *ONLY* if you are withdrawing from *ALL* of your classes this term
(See Registrar's website for deadlines to withdraw by current term *www.famu.edu/registrar*)

NOTE: Federal regulations require this office to inform all appropriate University departments of your intent to withdraw from this institution. This action could affect your current and future federal financial aid award(s).The Financial Aid Office will use the intent-to-withdraw date captured at the time this form was accessed to process the Return of Funds if applicable.

PERSONAL INFORMATION *(Complete Form, Print & Submit to the Registrar's Office)*

Last Name _____ First Name _____ Middle Initial _____

Student I.D. _____ Preferred E-mail _____

Please Do Not Enter Social Security #

Current Term: ☐ **Fall** _____ (Year) ☐ **Spring** _____ (Year) ☐ **Summer (A, B, C)** _____ Circle Session(s) Year

Last Date of Attendance: _____ **(Month, Date, Year)**

On Campus Housing ☐ **Yes or** ☐ **No**

WITHDRAWAL INFORMATION

Reason for Withdrawal: (Proper documentation must accompany this form)

☐ *Death* (Attach funeral program & death certificate)
☐ *Judicial* (Complete Second Form)
☐ *Medical* (Complete Second Form)
☐ *Military* (Attach Military Orders)
☐ *Personal* (No Documents Required)

Student's Signature **Date** **Advisor's Signature** **Date**

See attached sheet. I understand that I am liable for ALL FEES incurred.

Chairperson's Signature **Date** **Dean's Signature** **Date**

Once you submit this form, you will be withdrawn from the University

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Last Name _____ **First Name** _____ **Student ID** _____

Unable to Attend Classes From**:** _____ To: _____
mm/dd/yyyy mm/dd/yyyy

SUBMIT ORIGINAL FORM:
TO BE COMPLETED BY THEAPPROPRIATE OFFICIAL ONLY
Licensed Physician, Therapist, Judge, Attorney or Clerk of the Court

The student is authorizing the appropriate person to release the information requested to the University for the purpose of seeking a withdrawal from the University. This information will be used to determine if the student qualifies for a withdrawal. All sections that apply must be completed by the appropriate official. If not completed, the withdrawal process will be delayed. This office appreciates your cooperation.

In your own opinion, could the student attend class during the relevant period? ☒ **YES** ☐ **NO**

If "No", please specify the dates the student was unable to attend class and **ATTACH AN OFFICIAL LETTER ON YOUR OFFICIAL STATIONERY** briefly describing the student's condition. _____ to _____
mm/dd/yyyy mm/dd/yyyy

IMMEDIATE FAMILY MEMBER'S ILLNESS

Is the student providing sole round the clock care to his/her immediate family member? ☐ **YES** ☒ **NO**

What is the student's relationship to this family member? _____

What is the duration of extensive care needed? From: _____ To: _____
mm/dd/yyyy mm/dd/yyyy

Official's Name _____ Title _____ License# / State _____

Address _____ E-mail _____

Phone ( )

AUTHORIZED SIGNATURE OF APPROPRIATE OFFICIAL

_____ _____ _____
Signature of appropriate official Print Name Date
(***Original Signature ONLY – Do Not Use Stamp***)