INTERNATIONAL UNIVERSITY OF THE EAST

3333 Wilshire Blvd., Suite 600, Los Angeles, CA 90010
Phone: 213-947-3611 Fax: 213-947-3549 or Email: info@iueast.org

LEAVE OF ABSENCE FORM

_____
Last Name First Name Middle Date of Birth

_____
Mailing Address City State Zip Code

Phone Number: ( ) _____ Email:_____

TYPE OF LEAVE OF ABSENCE

( ) Medical (Doctor's Confirmation Required) Leave of Absence Start Date: _____
( ) Annual Vacation (Verification Required) Leave of Absence End Date: _____
( ) Other (May require additional documents & verifications) _____

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: _____ Medical License #_____

Signature: _____ Date: _____

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

Student Signature: _____ Date: _____