



Attachment B Return from Leave Form

Name: _____ R#: _____ Date: _____

Program/Track: _____ Campus/Distance: _____

Address: _____ City, State _____ Zip _____

Phone # (home): _____ Cell #: _____ Phone # (work): _____

Personal email: _____

Courses completed: _____

Expected Date of Graduation: _____

Leave was approved for: Fall _____(yr) Spring _____(yr) Summer _____(yr)

Returning Semester: Fall _____(yr) Spring _____(yr) Summer _____(yr)

I understand I must submit a Return From Leave form two months before the beginning of the returning semester. If I do not return the semester following the approved period of leave, I understand I will be dismissed from the program and will have to reapply to the Texas Tech University Health Sciences Center School of Nursing.

Student Signature

Date

For internal use only

Approved: _____ Denied: _____ Student notified via email by: _____

Comments: _____

Department Chair Signature

Date