



Request for Temporary Leave of Absence (TLOA)

Student Name: _____ SSN: _____

Address: _____

Phone - Home: _____ Cell: _____

Start date of TLOA: _____ Expected date of return: _____

Reason for your leave of absence: (You will be required to submit proper documentation to support the TLOA.)

___ Maternity ___ Health/accident ___ Military
___ Other (please specify reason) _____

For Financial Aid recipients:

The purpose of this form is to certify that you have an understanding of the financial aid implications of a leave of absence.

I, _____, understand that the following terms of the TLOA agreement apply if I am on a leave from Middle Tennessee School of Anesthesia for the dates listed above.

1. While I am on an approved leave of absence, my enrollment status will be reported to my lenders as Leave of Absence.
2. If I am notified by my lender(s) that my loans are in repayment, I will need to contact my lender(s) and request a hardship forbearance or economic hardship deferment.
3. While on approved leave of absence, I am not eligible for any additional federal student financial aid or private education loans.
4. Upon my return from leave of absence, any subsequent financial aid disbursements may be delayed until I again meet the standards for satisfactory academic progress towards the completion of my degree.
5. If I do not return from my leave of absence, I will be considered withdrawn as of the date I began the leave. I will have my tuition refund calculated on that leave date. Once the institutional and federal refunds are determined, I may incur a balance on my account which I will be required to pay.
6. If I do not return from my leave of absence, my loans will go into repayment based on the start date of the leave of absence. This could result in the depletion of some or all of my grace period of my student loan(s).
7. The leave of absence and any additional leaves of absence must not exceed a total of 180 days in any 12 month period pursuant to federal regulations.

NOTE: Any documentation that is submitted to support this leave will be reviewed by authorized MTSA Staff. By signing below, I authorize the release of information, including medical records, to the MTSA administration offices.

Student Signature: _____ Date: _____

Program Administrator Signature: _____ Date: _____

Financial Aid Director Signature: _____ Date: _____

Office Use Only:

Action Taken _____ Signature _____ Date _____

Copy of form given to: ___ Coordinator of Academic Support ___ Coordinator of Clinical Support ___ Director of Financial Aid