K&K Healthcare Training Center

STUDENT LEAVE OF ABSENCE REQUEST

(Please Print)

Date _____ **Class Start Date** _____

First Name _____ **Last Name** _____

Address _____

Phone Number _____ **Email** _____

Reason for Leave of Absence

_____

_____

_____

_____

By signing this form, I acknowledge and understand the following:

- I am responsible for adhering to the K&K Healthcare Training Center's policies regarding leaves of absence and re-enrollment procedures.
- I understand that a leave of absence may have implications for program completion timelines, tuition payments, and program availability.
- I will adhere to any additional requirements or processes required for re-enrollment after the leave of absence period.
- I understand that my request for a leave of absence is subject to approval by the program coordinator.
- I understand that I am required to resume my studies by the authorized return date; otherwise, the granted approval will become null and void.

Signature _____ **Date** _____

FOR OFFICE USE ONLY

Approval Granted: [ ] Yes [ ] No **Return Deadline** _____

Approval By _____ **Signature** _____

Date _____