



**ROSS  
UNIVERSITY**

EST. 1978

SCHOOL OF MEDICINE

**Office of the Registrar**

Campus: PO Box 266, Portsmouth, Dominica, West Indies

Administrative Offices: 630 US Highway 1, Suite 300

North Brunswick, NJ 08902

TEL: (732) 509-4600 FAX (732) 509-4820

Email: Registrar@RossU.edu

www.RossU.edu

**Academic Leave of Absence  
Clinical Sciences**

[Please print clearly]

Name: \_\_\_\_\_ Student ID# \_\_\_\_\_  
(Last, First, MI) (Nine-digit)

Address: \_\_\_\_\_  
(Street) (Apt. #) (City) (State) (Zip Code)

Telephone No: ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

I am applying for an ALOA to begin:

\_\_\_\_\_ Before AICM course (one semester only) Semester Dates \_\_\_\_\_ to \_\_\_\_\_  
[Not eligible for USMLE Step I Registration during this period]

\_\_\_\_\_ Before Clinical Rotations (up to 180 days - pending passing of Step 1; Date scheduled for Step 1 \_\_\_\_\_)

\_\_\_\_\_ During Clinical Rotations (up to 6-weeks to study for Step 2 CK or CS; must have a clinical rotation scheduled for return) Date Scheduled for Step 2 CK/CS \_\_\_\_\_

\_\_\_\_\_ Other (Explain) \_\_\_\_\_

I am applying for an ALOA starting on \_\_\_\_\_  
(Last Day of Full-time Attendance)

I understand that this requested ALOA ends on \_\_\_\_\_  
(Beginning date of following semester or clinical rotation or up to 180 day limit to sit for step I)

**By signing below, I am stating I understand the provisions listed on this application.**

An Academic Leave of Absence may be approved no more than **once in a 12-month period**. Additionally, this approved ALOA will place any prior student loans into grace period and if rotations do not begin by the approved date, you may be placed into repayment status through your lenders. **You are not eligible for an in-school deferment during this period.** For gaps of more than 30 days in the clinical curriculum, other than for an approved ALOA, you will be placed on Temporary Withdrawn status [TWD] and are subject to dismissal. **In order to be approved, an ALOA must be submitted prior to the beginning of the gap, otherwise you will be placed on TWD for that period.** This request must be submitted to and approved by the Clinical Dean and the New Jersey Office of the Registrar. This application may be faxed to **732-509-4820**.

**I have read and understand the University regulations regarding Academic Leaves of Absence as specified here and in the Student Handbook.**

\_\_\_\_\_  
Student's Signature Date

**For Office Use Only**

Dean's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Registrar's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Status changed on: \_\_\_\_\_ Term: \_\_\_\_\_