HORIZON UNIVERSITY

LEAVE OF ABSENCE FORM

2040 S. Brea Canyon Rd #100, Diamond Bar, CA 91765 Phone: 909-895-7138 Fax: 909-895-7143

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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) _______________________________________

Signature: ____ Date: __________________________

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:____

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Duration of medical leave of absence (in weeks): ________________________

Print Name:________________________________ Title: _________________________________

U.S. Medical License #: _____________________ Expiration Date: _______________________

Signature:_________________________________ Date: ________________________________

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

All other Leave of Absence: This section must be submitted and completed by the Administration

Leave of Absence Approved by: _______________________ Title: ____________________________

Signature: ____ Date: __________________________