

WITHDRAWAL REQUEST FORM

ACOM - Office of the Registrar

445 Health Sciences Blvd., Dothan, AL 36303

Phone: 334-699-2266 • Fax: 334-699-2268

Email: registrar@acom.edu



INSTRUCTIONS: Students considering withdrawing from ACOM should first contact the Associate Dean of Student Services to determine whether alternatives to withdrawal are available. Students receiving financial aid should **speak with Financial Aid BEFORE submitting this request.** This form should be used to withdraw from ALL classes for the current semester.

Please return completed form to: The Office of the Registrar
445 Health Sciences Blvd
Dothan, Alabama 36305
registrar@acom.edu

PERSONAL STUDENT INFORMATION: Please Print

Last Name: _____ First Name: _____ Middle: _____

Student ID No.: _____ Class of: _____ Class Level: _____

DOB: _____ Email: _____ Phone: _____

Address: _____

WITHDRAWAL INFORMATION:

Class Level: OMS I OMS II OMS III OMS IV

Term of Withdrawal: Fall Spring Summer Year: _____

Reason for Withdrawal: (please choose one)

Personal Medical Financial Transfer Other

Do you plan to return to ACOM? Yes _____ No
(Term / Year)

ACKNOWLEDGEMENT:

I, _____ hereby request that I be withdrawn from all registered courses
(Print Full Name)
and/or from the Alabama College of Osteopathic Medicine. I understand that I am solely responsible for determining the impact of withdrawal upon my academic record, charges, and financial aid and affirm that I have considered and understand the effects of this withdrawal. Furthermore, I understand that full withdrawal from a term will require readmission to the College and supporting documents may be required.

Student Signature: _____ Date: _____