

Leave of Absence

Name: _____

Student ID: _____

Address: _____

Telephone #: _____

Email: _____

Degree Program: _____

Type of leave requested

Proposed dates of leave

Maternity/parental leave

Start date: _____

Illness*

End date: _____

Compassionate leave

Employment leave

Other (Specify) _____

Signature: _____

Date: _____

Student

I am aware of this student's request for leave.

Signature: _____

Date: _____

Supervisor

Signature: _____

Date: _____

Graduate Coordinator

Division of Research and Graduate Studies Review

Leave Approved

Signature: _____

Date: _____

Dean of Research & Graduate Studies

*Please note that requests for leave due to illness must be accompanied by documentation from a certified health practitioner recommending temporary suspension of the student's program. All such documentation will remain confidential.