COMMONWEALTH UNIVERSITY
College of Medicine

STUDENT COURSE WITHDRAWAL FORM

STUDENT INFROMATION

Name: _____

Student ID: _____

Program/Department: _____

COURSE DETAILS

Course Title: _____

Course Code: _____

Instructor Name: _____

REASON FOR WITHDRAWAL:

_____

_____

_____

ACKNOWLEDGMENT:

I understand that by withdrawing from this course, I may affect my academic progress and financial obligations. I acknowledge that it is my responsibility to consult with my academic advisor and understand the consequences of this withdrawal.

Date (MM/DD/YYYY): _____ **Signature:** _____

Email:
info@cucom.org

Website:
https://www.cucom.org/

Phone:
+1 (240) 393 4946, +1 (234) 564 4564

Phone No:
+1(758) 286 2588

Admissions & Clinical Administrative Office:
909 Rose Avenue, Suite 400, North Bethesda, MD – 20852.

Campus Address:
No. 1, Beausejour Road, Gros Islet, Saint Lucia.

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INSTRUCTIONS:

- Complete all sections of this form.
- Submit the completed form to the Registrar's Office before the withdrawal deadline.
- Keep a copy of this form for your records.

REGISTRAR'S OFFICE USE ONLY:

Date Received: _____

Registrar Signature: _____

Comments: _____

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