Alhambra Medical University

Administration Office: 2215 West Mission Road, Suite 280, Alhambra CA 91801
Tel: 626-289-7719 Fax: 626-289-8641

COURSE WITHDRAW FORM

Please use ink (no pencil) **NO.** _____

Name: _____ Student ID: _____
Last(姓) First (名)

Quarter: ◯ Winter ◯ Spring ◯ Summer ◯ Fall Year: _____

Course No.	Course Title	Units
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Unit _____

Clinical Practice

Course No.	Clinic Course Title	Hours
_____	_____	_____
_____	_____	_____

Total Hours _____

Reason for withdraw: _____

_____

☐ Check Refund ☐ Credit to Account

Student Signature: _____ Date:_____

Clinic Director Signature: _____ Date: _____

Financial Aid Director Signature: _____ Date: _____

Academic Dean Signature: _____ Date: _____

University Registrar Signature: _____ Date:_____

Office Use Only

Student withdrawn class at _____week.

Tuition charges: _____%

Total refund: $_____ (see tuition refund form) (check #)

Method of Credit (mark one): ☐ Credit to Account ☐ Refund Check

Handled by : _____ Date: _____

Revised: 05/2016