JOHNS HOPKINS
U N I V E R S I T Y

School of Medicine
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Office of the Dean
Registrar

GRADUATE STUDENT STATUS CHANGE FORM

Memo (**original**) to: Registrar, School of Medicine, 147 Miller Research Building

(**copy**) to: Dr. Peter Espenshade, Associate Dean for Graduate Biomedical Education, Physiology 107B

From: ___________________________________ ____
Graduate Program Director Name Name of Program

Re: __________________________________ _____________________________________
Last name of student First name of student

Change effective date: _________________________ (mm/dd/yyyy)

Anticipated graduation date: _____________________ (mm/dd/yyyy)

Type of Change: ____ Leave of Absence * ____ Terminate ____ Return to FT Status ____ PT Status ____ Non-Resident Status

Reason for Change: ____

Leave is granted for a maximum of 1 year, with the possibility of a 1 year extension upon approval.

REQUIRED INFORMATION

a. If completing a Biomedical Careers Initiative Internship, indicate company name and department where the student will be working:

b. If student going on Leave of Absence is a foreign national, the International Office MUST be contacted at least 30 days in advance to ensure that: 1) the action does not unnecessarily place the student in violation of visa status and 2) the Department of Homeland Security is notified in such a way that the student can maintain status. **You must submit evidence that the International Office has been contacted with this form**.

c. Per Doctoral Board policy, students not returning from leave of absence within two years will be automatically terminated from the graduate program and will be required to reapply for admittance if they desire to resume studies.

d. Student **MUST** provide a mailing address (below) to which we can send communications regarding medical benefits while on leave of absence. Student returning from leave of absence **MUST** confirm their local mailing address (below) upon their return.

Address: ____

Policy Statement on Health Insurance Requirements:
*I verify that I have told this student that he/she will continue to be enrolled in benefits while on leave of absence and (1) that he/she is responsible for all premiums not paid by the program and (2) if he/she does not want benefits during the leave, he/she must email the Benefits Desk in the Registrar's Office at sombenefits@jhmi.edu to get information on waiving benefits while on leave.

____ _________________
Signature of program coordinator or program director Date

This acknowledges I have been notified of the Health Insurance Requirements policy

____ _________________
Signature of student Date

Please Note: For students granted a medical leave, School of Medicine policy allows the program/department to pay Health and Dental Insurance premiums for a period of up to one year if requested by the student.