

CUNY SCHOOL OF PUBLIC HEALTH

A Graduate School of Public Health & Health Policy

Request for Withdrawal from Program Form

MPH _____ MS _____ DPH _____

* Please fill out and forward the completed form to the Office of the Registrar

Student Name: _____
Last First M.I.

Address: _____
Number and Street Apt. # City State Zip Code

Status at SPH: Graduate Doctoral (_____) _____
Phone Number

CUNYFirst Empl ID: _____ ID#: ____/____/____

Email Address: _____

Effective Date of Requested Withdrawal: _____

Reasons for Requested Withdrawal: _____

_____/_____/_____
Student's Signature Date

Department Chair

Approved Denied: _____
Comment if Denied

Department Chair (Print Name) Signature Date

****This form will not be processed without the student's and Department Chair's signature****

For Registrar's Office Use Only

Processed by Print Name Signature Date