



A R U B A
XAVIER UNIVERSITY
X U S O M
S C H O O L O F M E D I C I N E

Pre-Med/Basic Science Program Withdrawal Form

Student Data

Student
Name:

Last

First

M.I.

Student ID:

SSN/ SSI

Student E-Mail

Student Phone Number

Student
Address:

Street

City

State/ Zip

I am requesting to voluntarily withdraw from Xavier University School of Medicine Aruba, effective immediately,

for the following reason(s):

Academic Performance

Financial Hardships

Other (explain): _____

Student Signature (REQUIRED)

Date (REQUIRED)

For Xavier University Administration Use Only

Status
of
Request

ACCEPTED

DECLINED

Dean's Signature

Date

Reason for Decline