



**Request to Withdrawal from
The Warren Alpert Medical School of Brown University**

Please complete this form, sign the bottom and email to AMS-records@brown.edu

Name: _____ Date submitted: _____

Current MD class: _____ Date of matriculation: _____

Effective date of your withdrawal: _____

Current Address: _____

Contact Information after withdrawing: _____

Non-Brown email address: _____

Reason for Withdrawal (select only one below):

- Withdrawal – Academic Reasons
- Withdrawal – Financial Reasons
- Withdrawal – Health Reasons
- Withdrawal – Other Reasons
- Transfer to Other US Medical School

Comments



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Signature of Student

Date

Associate Dean for Student Affairs

Date

Director of Financial Aid

Date

Senior Associate Dean for Medical Education

Date

Please note that following voluntary withdrawal from The Warren Alpert Medical School, students are no longer eligible for readmission