UNIVERSITY of ST. AUGUSTINE for HEALTH SCIENCES

Program Readmission Request

Name: _____ ID: _____

USAHS Email: _____ Outside Email:_____

Signature: _____ Date:_____

Campus: ◯ St. Augustine, FL ◯ Miami, FL ◯ Austin, TX ◯ Dallas, TX
◯ San Marcos, CA ◯ Distance

Program _____ Specialty _____
Circle one: Residential Flex Hybrid NA

Effective Trimester of Return: Fall _____ Spring _____ Summer _____
(year) (year) (year)

Registrar Review
Is the student on hold? Yes ◯ No ◯ Holds:_____

Is the student on Academic Warning/Probation? Yes _____ No _____

Notes: _____

Admissions
Does the student meet requirements for the program selected? Yes ◯ No ◯

Print Name _____Signature _____ Date_____

Financial Aid (Bursar if Self-Pay)
Student counselled on costs/ FA? Yes ◯ No ◯

Print Name _____Signature _____Date_____

Program Director
Approved? Yes ◯ No ◯ Expected Grad Year/Term _____

Print Name _____ Signature_____ Date _____

Registrar Final Review

Re-entry date _____

Print Name _____Signature _____Date_____

Certified B Corporation