

E-Mail to:  
 Registrar's Office  
 registrar@ndm.edu



NOTRE DAME  
 OF MARYLAND  
 UNIVERSITY

YEAR & SEMESTER _____
--------------------------

## COURSE WITHDRAWAL FORM

Student ID no. \_\_\_\_\_ Name \_\_\_\_\_  
*Last* *First*

Please check your program:  Women's College  College of Adult Undergraduate Studies  Graduate Studies  Pharmacy  
 MCT  PDI  CASE  Other \_\_\_\_\_

Preferred phone number \_\_\_\_\_ This is:  Home  Cell  Work

- I am withdrawing from all my courses this semester
- I request permission to withdraw from the following courses: Today's date \_\_\_\_\_

Course ID	Section	Lab	Auditing	Course title	Credit hours	Attended class?
<i>Sample:</i> BUS211	01		✓	<i>Principles of Accounting I</i>	3	✓
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Total number of credits before withdrawal \_\_\_\_\_ Total credits after withdrawal\* \_\_\_\_\_

\*An institutional withdrawal form has to be completed IF you plan to withdraw from the institution. This form only withdraws you from your active classes.

Reason for Withdrawal: \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
*Academic Advisor's signature* *Date* *Student's signature* *Date*

*By my signature, I acknowledge my responsibility for payment of the tuition and fees generated by this withdrawal. I have read and understand the University policies with respect to withdrawal and refunds as posted on the Registration Course and Exam Schedules page of the website.*

Should the above transaction reflect a credit balance on my student account, I authorize the following:  
 Allow credit to remain on my account  
 Credit my:  MasterCard  Visa  Discover Account number \_\_\_\_\_ Exp. date \_\_\_\_\_  
 Mail refund check to the following address: \_\_\_\_\_

**PLEASE RETURN ALL COPIES OF THIS SIGNED FORM TO THE REGISTRAR'S OFFICE FOR PROCESSING**  
 Copies: White: Registrar's Office Yellow: Business Office