



Office Use Only

Office of Financial Aid
2019-2020 Study Abroad Form

Student Name: _____

SSN (last four digits): _____ Phone Number: _____

Student Type: WOM CAUS GRAD PHARM

Notre Dame of Maryland University Sponsored Study Abroad Program: Yes No

Location of Trip: _____

Total Cost of Trip: _____

Study Abroad Awards: Yes No

Name of Award: _____

Amount: _____

Semester(s) of Study Abroad Program:

Fall Spring Winter Summer Fall and Spring

Start and End Date of Trip: _____ **Number of Credits** _____

If you would like to receive additional financial aid for the study abroad program, please select from the following financing options:

Alternative Loan

PLUS loan

Other (Please specify) _____

If you would not like to receive additional financial aid for the study abroad program, please check the following box:

I would like to leave my financial aid unchanged. I do not want to receive additional financial aid for the study abroad program.

Signature: _____

Date: _____