



Dental Assistant Education Center Withdrawal Form

Effective Withdrawal Date: _____

Today's Date: _____

Program : _____

Student Name: _____

Student address: _____

Last 4 Digits of Soc. Sec. No.:XXX-XX-_____ Student ID# _____

Student Date of Birth: _____ Phone Number: _____

Primary Reason for Withdrawal-Required

- ☐ Work schedule conflict
- ☐ Relocating
- ☐ Health or medical concerns
- ☐ Financial Difficulties
- ☐ Childcare issues
- ☐ Other; Please write description

I understand that if I withdraw I will be responsible for payment of any collection fees or attorney fees incurred by The Academy. Please refer to the refund policy in the school catalog.

STUDENT SIGNATURE

DATE

SCHOOL'S APPROVED AGENT

DATE

