



Location: 60 Haven Avenue New York, NY 10032
Phone (212) 305-3400 Fax (212) 342-3955
Mailing Address: Student Health Service, 630 W. 168th St., Mailbox 77, New York, NY 10032

Dean's Verification of Approved Leave for Students Requesting Insurance Coverage During Leave from Columbia University Medical Center

Medical Leave Non-Medical Leave

Student Name: _____

Student DOB: _____ Student Uni _____

Leave Begins _____ Anticipated Return _____
mm/dd/yyyy mm/dd/yyyy

This certifies that the above named student will be on an approved leave during the period noted above, and will return to CUMC on the indicated date. *

_____ Signature of School Official	_____ Date
_____ Print Name & Title	_____ Telephone Number
_____ School/Program	

** Leaves are limited to one insurance year. During an approved leave, the student is responsible for paying both the SHS fee and the Aetna Student Health fee if s/he wishes to continue the Aetna Student Health coverage. Student must have completed at least one semester at CUMC prior to leave.*

Enrollment is for the period of 8/17 _____ through 8/16/ _____.

Student paid by _____ the amount of \$ _____ on _____
Check/money order mm/dd/yyyy

Payment received by: _____ Signature _____
Print

Student Name _____ Signature _____
Print