



AMERICAN UNIVERSITY
SCHOOL OF MEDICINE
ARUBA

Re-Admittance Form

Student Information

Student Name: _____
Last First M.I.

Student ID: _____
AUSOMA ID Student E-Mail Student Phone Number

Student Address: _____
Street City State/ Province

I am requesting *Re-Admittance* for the following reason(s):

Returning student previously attended

Required additional time for USMLE Step 1 Exam

Required additional time for USMLE Step 2 CK Exam

Required additional time for USMLE Step 2 CS Exam

Other (explain): _____

Last Date of Attendance _____ Expected Start Semester _____

Guidelines for Re-Admittance:

*To be considered for re-admittance your student file must be complete.
Return this form to the Office of the Registrar for processing.*

Student Signature (REQUIRED)

Date (REQUIRED)

For Registrar Use Only

**Status
of
Request**

ACCEPTED DECLINED

Approval Signature Date

Reason for decline _____