SCHOOL of NURSING AND HEALTH STUDIES (SoNHS)

Readmission Following Academic Dismissal – All Programs

**All request must be completed and submitted to the
SoNHS Student Affairs Committee 10 days prior to the regularly scheduled meeting.
***Refer to the Leave of Absence Policy in the SoNHS Policy and Procedure manual.**

STUDENT NAME   STUDENT ID #   DATE

CURRENT ADDRESS W/STREET, CITY, STATE, ZIP

E-MAIL _____HOME PHONE _____WORK PHONE _____

Previously Enrolled PROGRAM
____ BHS   ___ BSN (PL/AT)   ____ RN-BSN   ____ BSPH   ___ PhD

MSN:
___Adult-Gerontology NP (AGNP)
___Women's Health NP (WHNP)
___ Pediatric NP (PNP)
___ Family NP (FNP)
___ Nurse Educator (NE)
___Psychiatric Mental Health NP (PMHNP)
___Neonatal NP (NNP)
___Acute Care Pediatric NP (ACPNP)

DNP:
___Adult-Gerontology NP (AGNP)
___Women's Health NP (WHNP)
___ Pediatric NP (PNP)
___ Family NP (FNP)
___ Certified Registered Nurse Anesthetist (CRNA)
___Acute Care Pediatric NP (ACPNP)
___Post Master's

____ Other (i.e. certificate programs)   Program Name: _____

What was the semester you completed that resulted in your dismissal? _____

What semester do you wish to be readmitted? _____
- *If the semester of readmission is less than six months from the semester of dismissal, a petition for exception form is also required.*

For which program do you wish to be readmitted? _____

NOTE TO ALL STUDENTS: Please be aware that readmission will be on a space available basis.
  ___ *Yes, I am aware of the above stated information*
  ___ *No, I will need to contact the Program Director.*

Student Initial:_____

APPLICATION FOR READMISSION Process and Considerations
☐   Contact the Program Director:
         a. Confirm space is available if readmitted to a clinical program
         b. Discuss if science courses will expire during the program you are applying for readmission
☐   Apply to UMKC if greater than 1 academic year for undergraduate and graduate students
☐   Be aware that you will be admitted under the new catalogue year
☐   All individuals requesting readmission must meet current program requirements
☐   Be prepared you may need to resubmit background checks, drug screens, and other pertinent
         information for the clinical setting
☐   Complete and submit this form to the academic advisor.

Please attached a typed explanation of the circumstances that supports readmission and why it should be considered. ***The brief explanation needs to be limited to 600 words or less on a separate document.***

_____   _____

Student Signature and Date of Application   Reviewed by Academic Advisor (Signature & date)

_____

Program Director Signature and Date

_____   _____

Tentative Date of Next Student Affairs Committee Meeting   Date Received in Student Services

This request will be reviewed at the next Student Affairs Committee meeting and a final decision will be emailed to you.

Student Affairs Decision and Date

Approved and Date _____

Not Approved and Date _____

Student Affairs Committee Chair Signature & Date Email (with Read Receipt) Sent to Student:

_____