



ADMISSION/ENROLLMENT CANCELLATION REQUEST

THIS FORM MUST BE RECEIVED IN THE REGISTRAR'S OFFICE BEFORE THE FIRST DAY OF CLASS.

First Name Middle Name Last Name

Address

City State Zip

CWID Date of Birth Phone

E-mail Address

SEMESTER OF CANCELLATION: Summer 20__ Fall 20__ Spring 20__

Have you attended any classes for the semester you are canceling? Yes No

Will you be attending OSU the following semester? Yes No Unknown

Comments: _____

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Student Signature _____ Date _____
(Required)

Office Use Only	<input type="checkbox"/> C3 Code Added	<input type="checkbox"/> Cancelled
Processed by: _____		Date: _____