

Full Name: _____

TMSAS ID: _____

Permanent Address: _____

Telephone Number: _____

Email Address: _____

I request deferral from the entering class of _____ to the entering class of _____.

Reason(s) for requesting a deferral (provide as much detail as possible) : _____

I understand that this deferral is until the beginning of the academic year noted above. I also understand that I must contact the Office of Admissions and Student Affairs prior to March 1st of the deferred academic year to confirm my enrollment intentions for the following academic year. If I fail to complete this notification, I understand my application to McGovern Medical School at UTHealth Houston will be withdrawn and reapplication will be required if enrollment is desired. I understand that it is my responsibility to contact McGovern Medical School at UTHealth Houston with any change of address, phone number or email address in the interim.

I understand that any financial support offered (i.e. scholarship funds) for my original year of enrollment will be voided and I will be reconsidered for awards among the pool of accepted students in the year of my actual enrollment.

In addition, I understand that during the deferred year I am not considered an enrolled student at McGovern Medical School at UTHealth Houston, I do not qualify for financial aid, and I am not eligible for school resources, including student health/mental health services and liability coverage.

Applicant's Signature: _____ **Date:** _____

Approved Denied OASA Signature: _____

Stipulations: _____