St. Cloud State University
Program Waiver Form for Leaving Program

Program Name _____

Term _____

I am fully responsible for my person, for any occurrence as part of my travel including, but not limited to; my medical issues, my financial issues, and my safety after leaving this program. I understand the SCSU group health insurance coverage is only available during the published program dates and I am responsible for obtaining my own individual insurance if I choose to travel beyond those dates. I release all claims against officers and employees of St. Cloud State University, of the Minnesota State Colleges and Universities System and of the State of Minnesota.

Check which applies and fill in appropriate dates and times:

____ I understand that I am leaving the group from _____ to _____ and will continue with the group as of _____ (Date and Time in current location). While not with the group the statement in the box above applies. I agree to return to the group and continue with the program at the agreed and signed date/time on this form.

OR

_____I understand that the education abroad program has ended on _____ (Ending Date and Time in current location) and I accept the terms of the statement in the box above.

_____

Participant: Print Name Signature Tech ID Date

Program Director: Print Name Signature Date

Additional Comments or Notes by Program Director:

Turn into the Center for International Studies, Education Abroad Office, Lawrence Hall G08 after signatures.