



SABA University School of Medicine
c/o R3 Education Inc.
27 Jackson Road, Suite 301
Devens, MA 01434
U.S. Fax: 978-862-9699

LICENSURE EXAM PREP TIME

(Required if time off is 30 days or more)

Student Name: _____
Last First

Email Address: _____

Estimated Graduation Date: _____

Note: A gap in your education may require an adjustment to your estimated graduation date.

I am requesting time off to study for:

STEP I (REPEAT) STEP 2CK STEP 2CS MCCEE MCCQE1

Start date: mm____/dd____/yy____ End date: mm____/dd____/yy____

Estimated Exam Date: mm____/dd____/yy____

Are you taking a Review Course? Yes No

If yes, name of course: _____

Review Course dates: mm____/dd____/yy____ to: mm____/dd____/yy____

Student Signature: _____ Date _____

Please return completed form to the Clinical Department by fax or email.

Office Use Only

Initialed by: _____ Date: _____