



Office Use Only

**Office of Financial Aid**  
2020-2021 Study Abroad Form

Student Name: \_\_\_\_\_

SSN (last four digits): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Student Type:     WOM     CAUS     GRAD     PHARM

**Notre Dame of Maryland University Sponsored Study Abroad Program:**     Yes     No

**Location of Trip:** \_\_\_\_\_

**Total Cost of Trip:** \_\_\_\_\_

**Study Abroad Awards:**     Yes     No

Name of Award: \_\_\_\_\_

Amount: \_\_\_\_\_

**Semester(s) of Study Abroad Program:**

Fall     Spring     Winter     Summer     Fall and Spring

**Start and End Date of Trip:** \_\_\_\_\_    **Number of Credits** \_\_\_\_\_

If you would like to receive additional financial aid for the study abroad program, please select from the following financing options:

Alternative Loan

PLUS loan

Other (Please specify) \_\_\_\_\_

**If you would not like to receive additional financial aid for the study abroad program, please check the following box:**

I would like to leave my financial aid unchanged. I do not want to receive additional financial aid for the study abroad program.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***This form contains personally identifiable information.***  
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