

MUSM CHANGE OF SCHEDULE FORM

All schedule changes must be completed four weeks prior to the start of the first changed course.

I. This section to be completed by the Student

Student Name: _____ Phone Number: _____

Courses to be Added:

Course Name and Number	Course Dates	Chairman's Signature	Date

Courses to be Dropped:

Course Name and Number	Course Dates	Chairman's Signature	Date

Date _____ Student Signature _____

II. Student Advisor

_____ Student **has** permission to proceed with the requested schedule change.

_____ Student **does not have** permission to proceed with the requested schedule change, see attached explanation.

Date: _____ Student Advisor _____

III. Office of Clinical Education

_____ Student **has** permission to proceed with the requested schedule change.

_____ Student **does not have** permission to proceed with the requested schedule change, see attached explanation.

Date: _____ Associate Dean _____
(or designee)

IV. Office Use Only

Date received _____ Copies to: Registrar _____ Preceptor _____
Preceptor _____ Preceptor _____
Preceptor _____ Preceptor _____