

MEDICAL STUDENT REQUEST FOR CHANGE OF EXAMINATION DATE

STUDENT'S NAME: _____ TODAY'S DATE _____

EMAIL ADDRESS _____ CELL PHONE _____

COURSE TITLE: _____ DATE OF EXAM: _____

1ST CHOICE OF RESCHEDULED DATE: _____

2ND CHOICE OF RESCHEDULED DATE: _____

REASON FOR REQUESTING A CHANGE OF EXAMINATION DATE/TIME

IF IT IS FOR A MEDICAL REASON, IS A DOCTOR'S LETTER ATTACHED? _____ YES _____ NO

I FEEL THIS IS A LEGITIMATE AND RESPONSIBLE REASON FOR BEING GRANTED PERMISSION TO CHANGE THE DATE OF THE ABOVE EXAMINATION.

STUDENT'S SIGNATURE

PLEASE COMPLETE THIS FORM AND SUBMIT IT TO THE SCHOOL OF MEDICINE AND HEALTH SCIENCES DEAN'S OFFICE FOR APPROVAL.

DEAN'S OFFICE APPROVAL

SIGNED: _____ TODAY'S DATE: _____

COMMENTS:

