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:

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