UCF COLLEGE OF MEDICINE
COURSE CHANGE REQUEST FORM

This form must be submitted **at least 6 weeks prior** to the start of the rotation to be changed. Submission of this request does not constitute approval.

Student Name: _____

PID: _____ **Date of Submission**: _____

ADD: Course Number:	Rotation Dates:
Course Title:	
Location:	
DROP: Course Number:	Rotation Dates:
Course Title:	
Location:	
Reason for Change:	

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Course Title:	
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Location:	
DROP: Course Number:	Rotation Dates:
Course Title:	
Location:	
Reason for Change:	

☐ I hereby acknowledge that I have discussed the above changes with my Academy Leader, Dr. _____. *(Please print name)*

Academy Leader Signature Approval: _____

Student Signature: _____

FOR OFFICE USE: APPROVED_____ PEOPLESOFT_____OASIS_____STUDENT_____DENIED_____