

LOYOLA UNIVERSITY CHICAGO STRITCH SCHOOL OF MEDICINE

Office of Registration and Records - Room 220  
2160 S. First Avenue, Maywood, IL 60153

# ELECTIVE CHANGE OF DATES FORM

Student Name \_\_\_\_\_ Class of \_\_\_\_\_

Title of Course \_\_\_\_\_

Course No.: \_\_\_\_\_ F/T \_\_\_\_\_ P/T \_\_\_\_\_

## ORIGINAL DATES

PERIOD: \_\_\_\_\_ DATES: \_\_\_\_\_ TO: \_\_\_\_\_ # \_\_\_\_\_ of Wks  
(Month/Day/Year) (Month/Day/Year)

## NEW DATES

PERIOD: \_\_\_\_\_ DATES: \_\_\_\_\_ TO: \_\_\_\_\_ # \_\_\_\_\_ of Wks  
(Month/Day/Year) (Month/Day/Year)

Name of Course Supervisor: \_\_\_\_\_

Department: \_\_\_\_\_ Hospital: \_\_\_\_\_

CHANGE OF DATES APPROVED BY: \_\_\_\_\_  
(Signature of Course Supervisor or Designate)

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

**Must** be signed by elective course supervisor or departmental elective coordinator.

<p>Office Use Only</p> <p>Schedule Changed _____</p>
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