Boston University School of Medicine
Third Year Clerkship
Change of Schedule Form

Name: ___________________________  Date: ___________________________

Box: ___________________________

Change Requested: ___________________________
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Students’s Signature     Signature of Supervisor of Clerkship*

*PLEASE NOTE: ALL CHANGE OF SCHEDULE FORMS REQUIRE SIGNATURE RELEASE OF SUPERVISOR PRIOR TO PROCESSING BY THE OFFICE OF THE REGISTRAR

RETURN COMPLETED FORM TO:
THE OFFICE OF THE REGISTRAR
715 ALBANY ST.  RM. A414
BOSTON, MA 02118