

Boston University School of Medicine
Division of Graduate Medical Sciences

Medical Campus
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**DIVISION OF GRADUATE MEDICAL SCIENCES
BOSTON UNIVERSITY SCHOOL OF MEDICINE**

**PETITION TO WAIVE
BIostatISTICS COURSE**

Date: _____

Name (print): _____
Last First

BU ID # _____

Signature: _____

Local Address: _____
Street Apt. #
City State Zip Code

BU E-mail Address: _____

Name of College (Biostatistics Course taken): _____

Name of Course: _____
(Ex., Elementary Biostatistics)

Course Number: _____
(Ex., . AN700)

Please attach a copy of your transcript, course description and/or syllabus.

(Below this line is filled in by GMS Faculty/Staff)

Major Professor: _____

Major Professor's Signature: _____ Approved ☐ Not Approved ☐ Date: _____
Comments: _____

Chairman's Signature: _____ Approved ☐ Not Approved ☐ Date: _____
Comments: _____

Action of Division Chairman Comments: _____ Approved ☐ Not Approved ☐ Date: _____

