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

Name: _____ **Date:** _____

Box: _____

Change Requested: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

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