

**BOSTON UNIVERSITY SCHOOL OF MEDICINE  
FOURTH YEAR REQUIRED COURSE/ELECTIVE  
ADD/DROP FORM**

\_\_\_\_\_  
Name    email    Date

ADD                           DROP                           BLOCK DATES: \_\_\_\_\_

COURSE NUMBER: \_\_\_\_\_                          COURSE NAME: \_\_\_\_\_

\_\_\_\_\_  
Student's Signature    \*Signature of Supervisor/Administrator of Required Course/Elective

**WHEN CHANGING YOUR SCHEDULE YOU MUST COMPLETE A SEPARATE FORM FOR THE ELECTIVE TO BE DROPPED AND THE ELECTIVE TO BE ADDED.**

**\*PLEASE NOTE: ALL ADD/DROP FORMS REQUIRE SIGNATURE OF SUPERVISOR OR ADMINISTRATOR PRIOR TO PROCESSING BY THE OFFICE OF THE REGISTRAR**

**RETURN COMPLETED FORM TO:**

**OFFICE OF THE REGISTRAR  
BOSTON UNIVERSITY SCHOOL OF MEDICINE  
72 E. CONCORD STREET, ROOM A414  
BOSTON, MA 02118  
FAX: 617 358-7551**