BOSTON UNIVERSITY CHOBANIAN & AVEDISIAN SCHOOL OF MEDICINE

THIRD YEAR SCHEDULE CHANGE REQUEST

Name _____ **Date** _____

Email _____ **UID** _____

Clerkship _____ **Course Number** _____

Block _____ **Site** _____

Requested Change _____

_____

_____

Student Signature _____

Return completed form to:

Email: camedreg@bu.edu

In Person:

Boston University Chobanian & Avedisian School of Medicine
Office of the Registrar
72 East Concord Street
A-building, room 414

Fax: 617-358-7551