



Medical Campus
72 East Concord Street, L-317
Boston, Massachusetts 02118-2526
T 617-638-5255 F 617-638-5740

Incomplete Grade Form

Student Information:

Last Name: _____ First Name: _____ BU ID #: _____

Email: _____

Program/Department: _____ Degree: _____

Semester: _____ Year: _____

Course Number: _____ Course Title: _____

Instructor's Name: _____

To be completed by the instructor:

Reason for Incomplete Grade: _____

To date, the student has completed _____% with an average of _____ for the portion of work completed.

If the student fails to complete the **missing work** by [date] _____, the **final grade** to be recorded is _____.

Assignment(s) to be completed:

<i>Requirement</i>	<i>Deadline</i>
_____	_____
_____	_____
_____	_____
_____	_____

Instructor's Signature: _____ Date: _____

_____ I have been in contact with the student regarding the 'I' grade for this course.

Student's Signature: _____ Date: _____

Note: Incomplete grades must be resolved within one year, at which time the grade will be converted to the final grade indicated above, or 'F' if no grade is indicated.

RETURN THIS FORM TO GMS REGISTRAR – L 309
ALL GRADE CHANGES MUST BE SUBMITTED TO GMS REGISTRAR