



# PERMISSION TO AUDIT A COURSE FORM

Submit Form To:

Graduate Medical Sciences

72 E. Concord Street, L-309, Boston, MA 02118

Email: [GMSRegistrar@bu.edu](mailto:GMSRegistrar@bu.edu)

Name \_\_\_\_\_ BUID \_\_\_\_\_

Academic Semester and Year \_\_\_\_\_ 20 \_\_\_\_\_ College \_\_\_\_\_

College of Course \_\_\_\_\_ Course Number \_\_\_\_\_ Section \_\_\_\_\_ Credits \_\_\_\_\_

Course Title \_\_\_\_\_

## INSTRUCTIONS AND NOTES:

This form is used to request audit status and must be filled in completely.

Semester dates can be viewed on the Registrar's Office website: [www.bu.edu/reg/calendars/semester/](http://www.bu.edu/reg/calendars/semester/)

The University Audit policy can be viewed at [www.bu.edu/academics/policies/auditing-courses/](http://www.bu.edu/academics/policies/auditing-courses/); individual schools/colleges may have additional policies. Please consult that college's Bulletin for details.

### **I request permission to attend this course on as audit basis. (check all boxes)**

- ☐ I understand that I will receive no credit for this course.
- ☐ I understand that the course will not apply toward my degree.
- ☐ I understand that I will be charged the regular standard tuition and fees for this course.
- ☐ I understand that courses taken on an audit basis cannot be paid for with financial aid.
- ☐ I understand that a mark of AU will be recorded on my transcript unless I fail to meet the conditions specified below, in which case a mark of "W" will be assigned.

*Please describe the conditions of participation agreed upon by student and instructor (i.e., class attendance, participation in discussion, presentations, assignments and grading, etc.).*

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

- ☐ I agree to allow the above named student to attend my course as an auditor, based on the conditions specified above.

Instructor Signature \_\_\_\_\_ Date \_\_\_\_\_

Program Director Signature \_\_\_\_\_ Date \_\_\_\_\_