REQUEST FOR EXAMINATION SCHEDULE CHANGE

Rescheduling a final examination will require a fee unless the reason involves an illness verified by Student Health Service or a physician, a death in the immediate family, three exams scheduled consecutively in one day, or four or more examinations in one day. **Complete sections 1-3 before obtaining the signature of the Associate Vice President for Academic Administration.**

1. Name: ________________________________ I.D.: ______________ Phone: __________________

Email: __________________ Local Address: ____

Request and Reasons: ____

____

____

List Course & Time & Date of Exam(s) requested to change (as presently scheduled): ______________

____

2.

Courses Currently Enrolled	Exam Date	Exam Time	Professor

I affirm that, should my request be granted, I will take the rescheduled examination at a time designated by the professor and pay a fee, if applicable.

____
Signature of Student *Date*

3. Professor's Recommendation: ___ Approve ___ Deny Comments:______________________________

____

Alternate Time & Date of Exam 1: ____

____
Signature of Professor *Date*

Professor's Recommendation: ___ Approve ___ Deny Comments:______________________________

____

Alternate Time & Date of Exam 2: ____

____
Signature of Professor *Date*

- -
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____
Signature of Associate Vice President for Academic Administration *Date*

____ Processing Fee ____ No Fee

Copies to: Teacher/Student/Student Finance/Associate VP/Academic Admin Rev.020315