UIC COLLEGE OF MEDICINE
UNIVERSITY OF ILLINOIS AT CHICAGO

Office of Student Affairs

CLINICAL EXPERIENCE ADD/DROP EXCEPTION REQUEST FORM

CLINICAL EXPERIENCE SCHEDULING INFORMATION

Student Name____

UIN____

Clinical Experience to be added/removed:__________________________________ Dept_______________

Clinical Coordinator Name:______________________________ Email: _______________________________

Date of Request______________ Start Date_____________ End Date _____________________

INSTRUCTIONS

To request an exception to the 4 week Add/Drop policy for clinical experiences, please complete the following. Exceptions to the 4 week add/drop policy will be considered under compelling extenuating circumstances.

1. **Complete clinical experience drop exception req form and explain in detail the reason(s) for the request**. Include supporting documentation if applicable.
2. **Submit Request Form to OSA Advisor for Review**.
3. **Submit Request Form to Faculty Advisor for Review**.
4. **Submit Request Form to Assistant Dean of Student Affairs for Review**.
5. **Submit Request Form to Registrar for Processing**.

REQUEST FOR EXCEPTION (TO BE COMPLETED BY STUDENT)

Reason for request to have clinical experience added/removed:

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________________________________ ____
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Signature____

Date_______________

Importance: ☐Essential ☐Important ☐Desirable

OSA Advisor Comments

Advisor Name____

Comments:____
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Signature____

Date________________

Faculty Advisor Comments

Advisor Name____

Comments:____
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Signature____

Date________________

Assistant Dean

Advisor Name____

Comments:____
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Signature____

Date________________