# Elective Approval Form

Date of Request: _____ Projected Graduation Date: _____

Student Name: _____ Mentor Name: _____

Elective Course Name:_____

Elective Course Number: _____ Department: _____

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Write a 400-600 word statement about how this course helps to fulfill educational and professional career goals:

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(Please sign in front of your mentor.)

Student Signature: _____ Date: _____

I, _____, have read the above student's statement and agree with this course as an elective towards the PharmD. Degree.

Witnessed by Mentor (Signature):_____ Date: _____

**Electives must be 5000 or higher and must be applicable to your pharmacy career goals. The course must be taken for a letter grade. Please return this form to the Office of Student Affairs the <u>same day</u> it is signed. Failure to do so may affect your graduation status.**