

Elective Approval Form

Date of Request: _____ Projected Graduation Date: _____

Student Name: _____ Mentor Name: _____

Elective Course Name: _____

Elective Course Number: _____ Department: _____

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

(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 same day it is signed. Failure to do so may affect your graduation status.