

**THE UNIVERSITY OF CHICAGO
DIVISION OF THE BIOLOGICAL SCIENCES
AND THE PRITZKER SCHOOL OF MEDICINE**

NAME: _____

DATE: _____

ADDRESS: _____

TELEPHONE: _____

Check One:

Graduate Student, Department of _____

Medical Student

I respectfully petition to waive the

5 month degree granting period

8 month degree granting period

My reasons are

Department and/or
Preceptor Approval: _____

Date: _____

Action Taken:

Date: _____

Dean of Students