Weill Cornell Graduate School of Medical Sciences

GRADE REVERSAL FORM

Student's Name: _____

Student's Program: _____

Full Title of Course: _____

Course Director's Name: _____

Academic Year of Course: _____

Quarters During Which Course is Scheduled: _____

Original Registration: _____ Credit _____ Audit

New Registration if any: _____ Credit _____ Audit

Original Grade and Date: _____ Grade _____ Date

New Grade and Date: _____ Grade _____ Date

Course Director's Signature: _____ Date: _____