Weill Cornell Graduate School of Medical Sciences

COURSE WITHDRAWAL FORM

Student's Name: _____

Student's Program: _____

Full Title of Course: _____

Course Director's Name: _____

Academic Year: _____

Course Quarter(s): _____

Original Registration: _____ Credit _____ Audit

Date of Withdrawal: _____

Student's Signature: _____ Date: _____

Course Director's Signature: _____ Date: _____