



# 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: \_\_\_\_\_