

**THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
PROGRAM OF GRADUATE STUDIES**

Return completed form to the Office of the Registrar, 147 Miller Research Building or to GradStdDsk@jhmi.edu

Last Name: _____ First Name: _____ Date: _____

Department/Program: _____

This form must be filled out completely and approved by the program director or the chair of the department. List below ALL School of Medicine courses you plan to attend during the academic year, plus any first term interdivisional courses. Changes in registration should be reported on a Change of Schedule Form which may be obtained in the Office of the Registrar, 147 Miller Research Building or [online](#). Changes in registration for courses must follow host division rules.

| Division | Department | Course # | Section # | Title of Course | Dates or term of course (if course is a year course, please indicate) | Check here if course is to be audited | For Office Use Only |
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Date: _____ Signature of Program Director/Chair*: _____

***Signer acknowledges that student meets pre-requisites/co-requisites for the course(s) being requested.**