

UConn HEALTH

STUDENT SERVICES
CENTER

Independent Study Authorization

The form must be submitted to the UConn Health Registrar either in person at AM039 of the Academic Building, or scanned and emailed to: registrar@uchc.edu. *Electronic signatures are not permitted.*

Name: _____ Student ID (or Net ID): _____

Course:

CLTR 5099 _____ DENT 5495 _____ PUBH 5495 _____ MEDS 6495 _____

Maximum Units/ Credits authorized by Instructor: ____

Year: _____ Fall _____ Summer _____ Spring _____

Name of Project to Appear on Transcript (please print clearly):

This form cannot be processed unless all signatures have been obtained.

Advisor: _____ Date: _____
Print Signature

Instructor: _____ Date: _____
Print Signature

Dean or Designee*: _____ Date: _____
Print Signature

**Required after fourth week of semester*

UConn Health Registrar's Office Use only			
Section: _____	Class Number: _____	Date Entered: _____	Initials: _____