UCONN HEALTH

Office of the Registrar

Independent Study Authorization

The form must be submitted to the UConn Health Registrar either in person at LM041, or scanned and emailed to registrar@uchc.edu. Typed signatures are not permitted; please submit with a DocuSign or wet signature.

Name: _____ **Student ID:** _____

Course: **CLTR 5099**☐ **DENT 5495**☐ **PUBH 5495**☐ **MEDS 6495**☐ **MEDS 5395**☐

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.

Student: _____ _____ **Date:** _____
Print **Signature**

Advisor: _____ _____ **Date:** _____
Print **Signature**

Instructor: _____ _____ **Date:** _____
Print **Signature**

Dean *or* Designee*: _____ _____ **Date:** _____
Print **Signature**

** Required after the fourth week of semester.*

UConn Health Registrar's Office Use Only

Section: _____ **Class Number:** _____ **Date Entered:** _____ **Initials:** _____

Website: https://health.uconn.edu/registrar **Email:** registrar@uchc.edu

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