



MARQUETTE UNIVERSITY GRADUATE SCHOOL

GRAD 6945: MEDICAL COLLEGE OF WISCONSIN

If you need any assistance completing this form, please contact the Graduate School at 414-288-7137.

Last Name: First Name:

MUID: Day Phone:

Program: Degree:

Reason for taking course at MCW:

NOTE: By signing this form you agree that you have read and understand all program requirements, which are available online at http://www.marquette.edu/grad/future_MUtoMCW.shtml. Depending on the academic calendar of the institution where the course is taken, you should be aware that if you take a course at MCW during your final term, your graduation may need to be delayed.

Student Signature: Date:

GRADUATE SCHOOL PLANS

MCW Department:

Title of MCW Course:

Course #: Section #: Credit Hour:

Term: Fall Spring Summer Year:

Course Start Date: Course End Date:

Signature of Adviser or DGS: Date:

FOR GRADUATE SCHOOL USE

Transcript Check

Graduate School Approval: Date:

Scanned to OTR and returned to Assistant Dean.

Initials: Date: