School of Medicine & Health Sciences
THE GEORGE WASHINGTON UNIVERSITY

Medical Student Request for Change of Examination Date

Please review the Exam Date Change Procedure prior to completing this form.

Student Name: Today's Date:

Email Address: Cell Phone:

Course Title: Exam Type/#:

Date of Exam:

1st choice of reschedule date:

2nd choice of reschedule date:

Reason for requesting a change of examination date/time:

If request is for a medical reason, is a doctor's letter attached? ◯ Yes ◯ No ◯ N/A

By signing below, I attest to each of the following:

- By rescheduling this exam, I am assuming the risk of missing testable content and having less time to study.
- It is my responsibility to look at the class schedule and be aware of what sessions, required or otherwise, I am missing.
- All information provided on this form is accurate to the best of my knowledge. I understand that providing false or inaccurate information pertaining to this request is considered a violation of the honor code.

Student Signature:

Please submit the completed form to Dean Goldberg (rmgoldb@gwu.edu). Your request will be reviewed and you will be notified of the determination.

Determination *(for administrative use)*

Request approved? ◯ Yes ◯ No

Signed: Date:

Notes: