CASE WESTERN RESERVE UNIVERSITY

DROP/ADD FORM

Last Name: First Name: _	ID#:					
Term:				School: (circle one)		
Fall 20 Spring 20 Summer 20	UG	G	SASS	NURS	LAW	Other:

DROP	ADD	CRN	SUBJECT	Audit Pass/Fail* (if applicable)	CR HRS	DAYS	INSTRUCTOR
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I agree to pay all tuition charges and other fees associated with my registration. I understand that I will be automatically billed for the CWRU Medical Plan during the fall and spring semesters unless I complete a waiver form within 30 days of the first day of class. I may obtain this form from the University Health Service.

ADVISOR SIGNATURE or PIN	DATE	DEAN'S SIGNATURE	DATE
STUDENT SIGNATURE	DATE *(INDERGRADUATE STUDENTS MUST APPLY FOR F IN DEAN'S OFFICE DURING THE LAST WEEF	

All forms must be processed within one week of approval date.