CASE WESTERN RESERVE UNIVERSITY
School of Medicine
DROP/ADD FORM

Last Name:_____ First Name:_____ Student ID # (7-digit):_____

Term: Fall 20_____ (July-Dec) Spring 20_____ (Jan-June) CCLCM Student: ☐

Drop	Add	Withdraw from Class	Subject	Code	Class #	Audit	Pass/ No Pass	Credit Hours	Days						Instructor signature (or attach written permission; printed Emails accepted).
☐	☑	☐	*Econ*	*102*	*1068*			***3.0***	**M**	T	**W**	H	F	S	*Dr. R. Smith*
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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.

Note: The SOM Registrar cannot enroll medical students in any subject codes ending in 651 or 701.

Important: If Pass/No Pass basis is offered by the class instructor and students elect this option, then read and initial:

_____ **I have reviewed my Plan Program of Study (PPOS.)**

_____ **The courses on this form are not a degree requirement (letter graded course). Please enroll me on a Pass/No Pass (P/NP) basis.**

STUDENT SIGNATURE _____ DATE _____ SOCIETY DEAN/ADVISOR SIGNATURE _____ DATE _____

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