



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 (or Net 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.

Advisor: _____ Date: _____
Print Signature

Instructor: _____ Date: _____
Print Signature

Dean or Designee*: _____ Date: _____
Print Signature

**Required after fourth week of semester*

UConn Health Registrar's Office Use only

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