Office of the Registrar

INCOMPLETE GRADE REQUEST FORM

Student Information
Academic Program:
☐ DO ☐ MSMHS-COM ☐ Pharmacy ☐ MSMHS-COP ☐ Education ☐ Joint MSPAS/MPH ☐ Public Health ☐ Nursing

Name __________________________________________ Class of _________ Student ID# ____________ (required)

COURSE INFORMATION

SEMESTER: ☐ SUMMER ☐ FALL ☐ SPRING YEAR ___________

Course Number ______________ Course Name __________________

REASON FOR INCOMPLETE GRADE:
________________________________________________________________________

WORK TO BE COMPLETED BEFORE REMOVAL OF INCOMPLETE:
________________________________________________________________________

DUE DATE FOR COMPLETION OF WORK: ________________________________

I acknowledge that I must complete the required coursework to clear my incomplete grade by the deadline indicated above. I further acknowledge that any incomplete grade that is still outstanding after one year will automatically be converted by the Office of the Registrar to a failing grade.

Student Signature ___________________________ Date __________

ALL INCOMPLETE GRADE REQUESTS MUST BE APPROVED BY THE DEAN/PROGRAM DIRECTOR PRIOR TO SUBMISSION TO THE OFFICE OF THE REGISTRAR.

Name of Instructor (please print) ________________________________________________
Instructor Signature ___________________________ Date __________

Name of Dean/Program Director (please print) ______________________________________
Dean/Program Director Signature ___________________________ Date __________

For Office Use Only:

Date Received: ____________________ INC Entered by: ☐ Instructor ☐ Registrar’s Office Date verified/processed: ____________________

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