



**SCHOOL OF PHARMACY & HEALTH PROFESSIONS
DEPARTMENT OF PHYSICIAN ASSISTANT**

Petition for Waiver of Regulation for the Department of Physician Assistant

Name: _____ Email Address: _____

Last Enrolled in the Physician Assistant Program: Term _____ Year _____

Requested return date to the PA Program: Term _____ Year _____

Reason for waiver request: (Choose which applies)

Extension of the twelve (12) months' leave of absence maximum _____

Extension of the four (4) years' Program completion time requirement _____

Use the space below to type/write your request for waiver of policy. Please provide all supporting documents with your request.

Student's Signature: _____ Date: _____

Advisor

- Support this position
- Do not support this petition (Comments (if any) are attached)

Advisor Printed Name: _____

Advisor Signature: _____ Date: _____

Program Director

- Support this position
- Do not support this petition (Comments (if any) are attached)

Program Director Printed Name: _____

Program Director Signature: _____ Date: _____

School of Graduate Studies Decision

- Approved
- Not approved

Dean of School of Graduate Studies' Signature _____

Date of Dean's Signature: _____