

## College of Health Sciences Change of Graduation Date

Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Major: \_\_\_\_\_

**Current** Grad Date: \_\_\_\_\_

**Desired** Grad Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Return signed form to the CHS Dean's Office for processing:  
Quinn 101, or via email at [chs-group@uri.edu](mailto:chs-group@uri.edu).**