FACULTY OF HEALTH SCIENCES
GA PETITION FORM

Name: ____________________________    ID: __________________

Major: ____________________________    Box number: ____________

Date: __________________

Briefly explain the reason for your request
(Relevant documents should be attached)

________________________________________

Signature: ____________________________

Department’s Comment:

Date: ______________    Name: ______________    Signature: ______________

GPHP Administrative Coordinator’s Comment:

Date: ______________    Name: ______________    Signature: ______________

GSC’s Decision:    [ ] Approved    [ ] Declined

Authorized signature: ____________________________

Date: ______________