HEALTH SCIENCE CENTER
TEXAS A&M UNIVERSITY

HSC Graduate Programs Degree Plan

☐ MS ☐ MSN ☐ PhD ☐ CHANGE

Name: _____ UIN: _____ DATE: _____

Program/Location: _____

Course Prefix	Course No.	Course Title	Credit Hours	Final Grade
		Total hours listed for credit		
PREREQUISITES OR OTHER COURSES Not applicable for Graduate credit				

I understand that additional course work may be added to this proposed course of study by my Advisory Committee, if such additional work is needed to correct deficiencies in my academic preparation.

Student Signature _____ Printed Name _____ UIN _____

Approval Recommended:

Committee Chair _____ Printed Name _____ Dept. _____

Member or Co-Chair _____ Printed Name _____ Dept. _____

Member _____ Printed Name _____ Dept. _____

Member _____ Printed Name _____ Dept. _____

Member _____ Printed Name _____ Dept. _____

Department Chair/Program Director _____ Associate Dean _____ Date _____

With few exceptions, state law gives you the right to request, receive, review and correct information about yourself collected on this form.

Approved copy sent to: ☐ Student ☐ Commitee Chair ☐ HSC Registrar

Revised 02/03/2014