Radiologic Technology Program - Schedule Change Form

Session (Circle one): **FALL** **WINTER** **SPRING** **SUMMER**

Clinical Facility _____

Student Name _____

Current Schedule _____

Effective Date New Schedule begins _____

Requested Schedule Change (please include dates & times)

_____

_____

Additional comments: _____

_____

Signatures:

Clinical Instructor _____

Student's Signature _____

Mt. SAC Faculty _____

****Remember, you cannot deviate by more than one hour of your assigned schedule****

Fax number: (909) 274-2466