LEWISTOWN HOSPITAL SCHOOL OF NURSING
STUDENT REQUEST FOR CHANGE OF STATUS

Student Name: _____
Date of Request: _____

Current Status: ___ **Part-time** ___**Full-time**

Request to Change to: ___ **Part-time** ___**Full-time**

____ **Withdrawal**

Requested Start Date of Change: _____

Comments_____
_____
_____
_____
_____

Signature: _____

Faculty Decision: ___ **Approved** ___ **Not Approved**

Comments_____
_____
_____
_____
_____

Signature: _____**Date:**_____
Signature: _____**Date:**_____
Signature: _____**Date:**_____