Change of specialty request form

Please complete all fields and return this form to the Graduate Programs Office in Cushing 202. For any questions, please call 617-552-4928 or fax 617-552-2121.

Requests for change in specialty are not automatically guaranteed. Each student’s situation is considered individually based on preparation and previous experience in the field as well as availability of space in the program requested. Additional information may be requested as needed.

Date: ____________________________________________

Name: ____________________________________________

Eagle ID: ___________________________________________

Term Entered Program: ________________________________

Current Advisor (NAME): ______________________________

I have discussed this request with my advisor: □ yes □ no

Specialty in which you began program (for master’s students):

□ Adult Geriatric Health □ CNS □ NP
□ Community Health CNS
□ Family Nurse Practitioner (FNP)
□ Palliative Care - Adult Health □ CNS □ NP
□ Forensics
□ Palliative Care - Community Health CNS
□ Palliative Care - Pediatric □ CNS □ NP
□ Pediatric Health □ CNS □ NP
□ Psychiatric Nursing CNS/NP
□ Women’s Health Nurse Practitioner (WHNP)

Specialty that you are requesting (ie. new specialty):

□ Adult Geriatric Health □ CNS □ NP
□ Community Health CNS
□ Family Nurse Practitioner (FNP)
□ Palliative Care - Adult Health □ CNS □ NP
□ Forensics
□ Palliative Care - Community Health CNS
□ Palliative Care - Pediatric □ CNS □ NP
□ Pediatric Health □ CNS □ NP
□ Psychiatric Nursing CNS/NP
□ Women’s Health Nurse Practitioner (WHNP)

□ I confirm I want to change specialties regardless of clinical year availability in the new specialty. I hereby release my clinical slot in my current specialty. Once released this decision is final

OR

□ I would like to retain my current clinical slot pending approval and notification of available clinical semester in my newly chosen specialty.

Student Signature (required): ____________________________

For Office Use Only:

First Available Clinical Semester: _______________________

New Specialty Department Name: _______________________

Signature (required): __________________________________

Graduate Office Associate Dean’s Signature: ___________________