FLORIDA KEYS COMMUNITY COLLEGE
COURSE SUBSTITUTION REQUEST

In accordance with college policy*, as academic advisor for __________________________________________________________, (Student’s name) (Student I.D. Number), who is seeking a degree in __________________________________________________________, a course substitution is requested for __________________________________________________________. (course prefix, number and name)

The substitute course is __________________________________________________________. (course prefix, number and name)

Reason:

_______ Course that better meets the student’s educational needs and objectives.

_______ Required course is not scheduled during the last term before graduation.

The student’s graduation date is ______________________. The student did not take the course in normal sequence for the following reason:

Comments:__________________________________________________________________________________________________

___________________________________________________________________________________________________________

_________________________          _____________________________________________________________________________

(Date)                                                                                                      (Advisor’s signature)

----------------------------------------------------------------------------------------------------------------------------------------------------------------------

Approval _______ Disapproval _______ Comments:____________________________________________________________

_________________________          _____________________________________________________________________________

(Date)                                                                                                   (Supervisor’s signature)

----------------------------------------------------------------------------------------------------------------------------------------------------------------------

Approval _______ Disapproval _______ Comments:____________________________________________________________

_________________________          _____________________________________________________________________________

(Date)                                                                         (Vice President’s signature)

----------------------------------------------------------------------------------------------------------------------------------------------------------------------

Approval _______ Disapproval _______ Comments:_____________________________________________________________

_________________________          _____________________________________________________________________________

(Date)                                                                         (Director of Enrollment Services’ signature)

*This application must be submitted no later than two (2) days prior to the first day of classes of the appropriate term. Independent study normally is not permitted for program substitution.

Crsub.doc CM 10/05