LOYOLA UNIVERSITY CHICAGO

COLLEGE OF ARTS AND SCIENCES
Department of Biology

PERMISSION TO REGISTER

This form is to gain permission to retake a course.
Please type or print clearly.

To be completed by the student:

Student: First and Last Name _____ Student ID number _____

Class Status _____ E-mail _____ Academic Advisor _____

Phone Number _____

Course Information:

Course Name: _____

Section Number: _____ Course Number: _____ Number of Credits: _____

Registration Appt. Date/Time: _____ Semester of Study: _____

Instructor Name: _____

☐ I have completed the required prerequisites to register for this course
☐ I took these prerequisites at another school (transfer credit)
☐ I am repeating this course because: _____
☐ I have contacted the instructor to discuss my desire to register for this class

Student Signature: _____ Date: _____

To be completed by Instructor for approval (listed above)

Instructor name (printed): _____

Instructor signature: _____ Date: _____

☐ Approved, Chairperson's Signature: _____ Date: _____

☐ Not Approved, Reason: _____

☐ Entered By: _____ Date: _____