**…/…/20..**

**TO THE DIRECTORATE OF THE INSTITUTE OF HEALTH SCIENCES**

I am a student of your institute, enrolled in the ............................................. Master's Program with / without Thesis, with student number .................................................... I would like to take the following courses due to ......................................reason.

I respectfully request your permission.

 **Student’s Name Surname**

 **Signature**

 **Phone Number:**

|  |
| --- |
| **COURSES TO BE TAKEN:** |
| **INSTITUTE AND PROGRAM TO WHICH THE COURSE IS AFFILIATED** | **CODE** | **NAME** | **CREDIT** | **ECTS** | **ELECTIVE INFORMATION** |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
| **ELECTIVE COURSE INFORMATION TO BE SUBSTITUTED ACCORDING TO THE CONNECTED CURRICULUM** |
| **INSTITUTE AND PROGRAM TO WHICH THE COURSE IS AFFILIATED** | **CODE** | **NAME** | **CREDIT** | **ECTS** | **ELECTIVE INFORMATION** |
|   |   |   |   |   |   |
|   |   |   |   |   |   |

\*\* According to the related curriculum, if the elective course is not counted as a substitute according to the related curriculum and extra courses will be taken, the second section should be left blank.

**EXPLANATION:** (Explanations regarding the courses to be taken by the student should be specified in this field if necessary.)

**APPROVED**

**…/…/ 20..**

 **………… ……………… ………… ………………………**

 **Advisor Approval Head of the Department**

**……… …………………**

 **Financial Affairs Approval**