**…/…/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**