

EAST CAROLINA UNIVERSITY
College of Allied Health Sciences
Department of Nutrition Science

REQUEST TO CHANGE ADVISOR

Date of change request: _____

Please indicate below the person initiating this request:

- Student
 Advisor

Student name

Banner ID

Name of Faculty member in Department of Nutrition Science with Graduate Faculty status who has agreed to serve as new Advisor: _____

Signature (New Advisor)

Date

Signature (Former Advisor)

Date

I understand that changing my Advisor may delay my completion of the MS in Nutrition program requirements:

Student Signature

Date

Describe how this change will affect the progress of your completion of the Non-thesis Project or Thesis Research component of your program: _____

Signature (Program Director)

Date