DECLARATION OF INTENT

INTERDISCIPLINARY GRADUATE CERTIFICATE IN WOMEN'S HEALTH

Domain	Department	Catalog Number	Class Name	Semester	Year	Credits
Foundation Course			**Issues in Women's Health**			3
I						
II						
III						
ELECTIVE						
			Target Completion Semester and Year			**15**

Name: _____ **Student ID#** _____

College/School (if applicable) _____

Graduation Year (if applicable)_____ **Degree** (if applicable) _____

Permanent Address:_____

City/State/Zip: _____

Phone: _____ **E-mail:** _____

Applicant's statement: The above information is accurate to the best of my knowledge. I agree to comply with the prescribed courses as mutually agreed upon by myself and a faculty representative of the Interdisciplinary Women's Health Graduate Certificate

Signature: _____ Date:_____

SIGNATURE FORM

Please obtain the appropriate signatures:

IGCWH Advisor Signature

_____ _____

IGCWH Certificate Advisor Date