

**ROLLINS SCHOOL OF PUBLIC HEALTH**  
**Office of Student Services**

**REQUEST FOR EXTENSION TO THE FIVE YEAR LIMIT**

Student Name \_\_\_\_\_

ID Number \_\_\_\_\_

Department \_\_\_\_\_

Date \_\_\_\_\_

***Assistant/Associate Director of Academic Programs***

\_\_\_\_\_  
Name and Signature

\_\_\_\_\_  
Date

Recommend extension until (Semester and year): \_\_\_\_\_

**Please check the appropriate box:**            **Approval**            **Disapproval**

***Attach any comments regarding this request on a separate sheet.***

***Department Chair or Approved Designee***

\_\_\_\_\_  
Name and Signature

\_\_\_\_\_  
Date

Recommend extension until (Semester and year): \_\_\_\_\_

**Please check the appropriate box:**            **Approval**            **Disapproval**

***Attach any comments regarding this request on a separate sheet.***

***Office of the Dean***

\_\_\_\_\_  
Name and Signature

\_\_\_\_\_  
Date

Recommend extension until (Semester and year): \_\_\_\_\_

**Please check the appropriate box:**            **Approval**            **Disapproval**

***Attach any comments regarding this request on a separate sheet.***

Office of Student Services

Processed by: \_\_\_\_\_

Name

\_\_\_\_\_  
Date

With department approval, an email may be attached in lieu of electronic or physical signatures.