



RESEARCH COLLEGE OF NURSING

GRADUATE DUAL TRACK FORM*

Student Contact Information

Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Primary Track: AGNP _____

CNL _____

EPHL _____

FNP _____

NE _____

DUAL Track: AGNPC _____

EPHLC _____

FNPC _____

NEC _____

I understand that in making this change to my track, it could result in additional course requirements and some courses already taken may not apply to this track.

Student Signature

Date

For Faculty Signatures Only

Primary Academic Advisor: _____
(Signature) (Date)

DUAL Academic Advisor: _____
(Signature) (Date)

Graduate Program Director: _____
(Signature) (Date)

For College Use Only

Approved by Dean: _____

Date: _____

Original to Registrar, copy to Primary Advisor, copy to DUAL Advisor, and GP Director.