ST. CLOUD STATE
UNIVERSITY **SCHOOL OF GRADUATE STUDIES**
A tradition of excellence and opportunity

Request for Change of Graduate Program Advisor

Please complete this form if you wish to change your graduate advisor. **Please print.**

NAME:
First Middle Previous Last

ADDRESS:
Street City State Zip Code

TELEPHONE: **E-MAIL:**

STUDENT ID: **SOCIAL SECURITY #:**
(Voluntary, for I.D. purposes only)

CURRENT PROGRAM:

PRESENT ADVISOR:

PROPOSED ADVISOR: **SIGNATURE** ____________________

REASON FOR CHANGE:

STUDENT SIGNATURE ____________________________ **DATE** ____________________

The student must obtain the signature of the department chair and the new advisor before returning this form to the School of Graduate Studies.

Return to: School of Graduate Studies
121 Administrative Services Building
St. Cloud State University
720 Fourth Avenue South
St. Cloud, MN 56301-4498
Fax to: 320.654.5371
E-mail to: grads@stcloudstate.edu

________________________________ __________
Graduate Coordinator/Director **Date**

________________________________ __________
Dean, School of Graduate Studies **Date**

☐ **APPROVED** ☐ **DISAPPROVED**

For Office Use Only

Date Notified ________________________ ☐ Student ☐ Student File ☐ Previous Advisor ☐ New Advisor