

# ST. CLOUD STATE UNIVERSITY™

*A tradition of excellence and opportunity*

## School of Graduate Studies REQUEST TO CHANGE GRADUATE PROGRAM ADVISER

Name \_\_\_\_\_  
Last First Middle Previous

SCSU E-mail \_\_\_\_\_ SCSU Student ID \_\_\_\_\_

Current Address \_\_\_\_\_  
Number & Street City State Country Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Current Adviser \_\_\_\_\_

Proposed Adviser \_\_\_\_\_ New Adviser's Signature \_\_\_\_\_

Program Enrolled in \_\_\_\_\_

My reasons for making this request are as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Additional space is provided on the back. Please check if you used the back*

Signature \_\_\_\_\_ Date \_\_\_\_\_

*The student must obtain the signature of the Graduate Coordinator and the new adviser before returning this form to the School of Graduate Studies.*

\_\_\_\_\_  
Graduate Coordinator/Director Date

\_\_\_\_\_  
Dean, School of Graduate Studies Date

Approved  
 Disapproved

**Return to:** School of Graduate Studies  
121 Administrative Services Building  
720 Fourth Avenue South  
St. Cloud, MN 56301-4498

Phone 320.308.2113  
FAX 320.308.5371  
E-mail [graduatestudies@stcloudstate.edu](mailto:graduatestudies@stcloudstate.edu)

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PS3

For Office Use Only

Date Notified \_\_\_\_\_  Student  Student File  Previous Adviser  New Adviser

