COPHS Request for Internal Course Override Approval
Texas Southern University

Please PRINT all information legibly.

Date: _____   **Term Requested:** _____

Name (first, last name): _____

T Number: _____ **Major:** _____

Phone: _____ **Email:** _____

Type of Override Request (check all that apply):

__ **Closed section (requires approval signature—Program Director)**

__ **Professional off-track course prereq/co-req error (requires approval--Associate Dean/Pharm. D. or Program Director/Health Sciences)**

__ **Exceed maximum hours (requires approval--Associate Dean)**

Course(s) requested for override:

CRN (20472)	Subject (PHAR)	Course # (212)	Section # (01)	Credit Hrs. (1)

Justification for request (must be specific): _____
_____
_____
_____

Program Director/Advisor Signature: _____

COPHS Associate Dean Signature (if required): _____