Curriculum Consultation Request Form

YYYYMMDD

Course/Program

|  |  |
| --- | --- |
| Originator: | |
| Faculty: Select a Faculty | |
| **School/Department/Unit:** **School/Department/Unit** | |
| **Contact Person:** **Name of contact person** | |
| **Email: email@ubc.ca** | **Phone: 250.807.XXXX** |
| **Proposed Curriculum Change:** | |

To be completed by respondent:

|  |  |
| --- | --- |
| Respondent: | |
| Faculty: Select a Faculty | |
| **School/Department/Unit:** **School/Department/Unit** | |
| **Contact Person:** **Name of contact person** | |
| **Email: email@ubc.ca** | **Phone: 250.807.XXXX** |
| **Response:**  Response: (X a box)  Support  No Relevance  DO NOT Support (reasons must be detailed below) | |
|  | |

Respondent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return signed form to originator.