Student Project Contract

This form must be completed by the student and turned in to Oksana Wisniewski no later than Friday, October 14, 2005.

Student Name: _____________________________ ID # __________________________

Phone #: ___________________________ E-mail address: __________________________

Pharmacy Project Faculty Advisor: ________________________________

Site Name: ____________________________________________________________

Faculty Phone #: ____________________ E-mail address: _______________________

TITLE OF PROJECT: _____________________________________________________

PROJECT OBJECTIVES:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I have met with the student and verify that we will be working on this project during the course of the Fall semester and that the goals and objectives can be met prior to Friday, December 2, 2005.

_______________________________________ ________
Signature of Pharmacy Project Faculty Advisor   Date

I have met with my Pharmacy Project Advisor and agree that this project can be completed during the course of the Fall semester. I will personally deliver the completed Student Grading Form and copy of my project to the Department Office no later than Friday, December 2, 2005 or I will receive an “Incomplete” grade for this project.

_______________________________________ ________
Signature of Student   Date