Course Scheduling Maintenance Form

Office of the University Registrar
classroomsched@uakron.edu

TERM: **YEAR:**

COMPONENT: ☐ Lecture ☐ Lab ☐ Discussion ☐ Other:

Distributed Learning Class: ☐ Yes ☐ No

Course Fee: ☐ Yes ☐ No

COURSE NUMBER:

Subject Catalog Section

COURSE NAME:

Credit Hour:

ACTION:

☐ **Cancel** (if cancelled, were students notified: ☐ Yes ☐ No)
☐ **Add**
☐ **Change**

Please check all that apply.

☐ Room ☐ Class Limit ☐ Instructor ☐ Time/Day ☐ Meeting Dates
☐ Course Title ☐ Course Non Print

MEETING DATES:

Begin:

End:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start Time							
End Time							

BUILDING:

ROOM:

INSTRUCTOR'S NAME:

INSTRUCTOR ID:

INSTRUCTOR PRINT? ☐ **Yes** ☐ **No**

ENROLLMENT CAPACITY:

DEPARTMENT CONSENT: ☐ **Yes** ☐ **No**

YOUR NAME:

APPROVAL, CHAIR/DIRECTOR: **DATE:**

E-MAIL or EXTENSION:

APPROVAL, DEAN: **DATE:**

Notes:

**Prior to submitting to the Office of the University Registrar, print this page for your records.*