# CHANGE OF PROGRAM

CALIFORNIA STATE UNIVERSITY, LONG BEACH  
College of Health and Human Services  
Department of Kinesiology  

PROGRAM FOR THE M.A./M.S. DEGREE

Name ____________________________ Phone (______) ____________________________  
(Last) (First) (M.I.)

Address ____________________________  
(Number and Street) (City) (State) (Zip.)

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<th>Course Title</th>
<th>Units</th>
<th>Date Completed (Sem./Yr.)</th>
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Student’s Signature ____________________________ Date ____________  
Department Graduate Coordinator ____________________________ Date ____________

Advisor’s Signature ____________________________ Date ____________  
Associate Dean, College of Health and Human Services ____________________________ Date ____________