WAYNE STATE UNIVERSITY
COLLEGE OF NURSING

Change in Doctor of Nursing Practice Project Committee

Student Name:		Date:
Student ID Number:	E-mail:	Telephone:

Note: This form must be completed and submitted to the Director of Advanced Practice and Graduate Certificate Programs for approval.

The Change in Committee is necessary for the following reason(s):

Former Committee (Type names)	**Proposed Committee** (Type names)	**(Access IDs)**
Chair:	**Chair:**	
Committee Member:	**Committee Member:**	
Committee Member:	**Committee Member:**	
Clinical Consultant:	**Clinical Consultant:**	

Chair:	***Date***	***Member added Signature:***	***Date***
Member Removed name:	***Date***	***Member added Signature:***	***Date***
Member Removed name:	***Date***	***Member added Signature:***	***Date***

Signature of Director of Advanced Practice and Graduate Certificate Programs	Date