**PUBLIC**[x]

**INDEPENDENT**[ ]

**PROGRAM CHANGE REQUEST FOR STAFF REVIEW**

**Name of Institution:**

|  |
| --- |
| University of Missouri-St. Louis |

[ ] **Title or CIP change**

[ ] **Combination program created out of closely allied existing programs**

[ ] **Add option to existing program**

[ ] **Add certificate program (from approved existing parent degree or stand-alone) \**attach curriculum***

|  |  |
| --- | --- |
| **Before the Proposed Change** | **After the Proposed Change** |
| Title of Old Program/Certificate | Degree | CIP Code | Title of New Program/Certificate | Degree | CIP Code |
|   | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

Attach a copy of the “before and after” curriculum, as applicable

[ ] **Delete program**

[ ] **Delete option**

[ ] **Place program on inactive status**

|  |  |  |
| --- | --- | --- |
| Click here to enter text. | Click here to enter text. | Click here to enter a date. |

Name of program/certificate/option Degree type and CIP code Date to delete or inactivate

[ ] **Change of address**

[ ] **Closed location**

|  |
| --- |
| Click here to enter text. |

Enter address change or address of closed location

List sites where changes on this form should be applied (such as main campus, all off-site locations, etc.):

|  |
| --- |
| Click here to enter text. |

**AUTHORIZATION**

|  |  |  |
| --- | --- | --- |
| Click here to enter text. |  | Click here to enter a date. |

Name/Title of Institutional Officer Signature Date

**Please save and email this form and supporting documents to:** **he.academicprogramactions@dhe.mo.gov**