WHOLE HEALTH CLINIC
DONGGUK UNIVERSITY LOS ANGELES

Clinic Prerequisite Waiver Request

Name: _____ **Student ID:**_____

Email: _____ **Phone Number:**_____

Degree Program: □ MAcHM (Master's program) □ DAcHM (Doctorate program)

[A] I am requesting a waiver of the prerequisite for the following course:

Term:_____ Course Code & Name: _____
(e.g. Spring 2024) (e.g. Internship Level 1 OBT)

[B] Prerequisite course(s) required: Course Code & Name: _____
(e.g. WM110 Western Medical Terminology)

[C] Provide the reason why the prerequisite course waiver should be granted to you:

By signing this waiver application, I accept full responsibility for any academic consequences of enrolling in the course without completing the required prerequisite or corequisite. I understand that this waiver does not entitle me to additional assistance from the instructor, does not guarantee I possess the necessary background to succeed, and does not exempt me from taking the prerequisite or corequisite courses if required for my degree program. Should I receive a grade of F, I will be required to retake the course, with the F grade remaining on my transcript, and I will be obligated to pay the standard tuition fee for the retake. Furthermore, I acknowledge that if I withdraw from the course after the late registration period, the pro rata refund policy outlined in the catalog and student handbook will be enforced.

I certify that the information in this application is true and complete in all respects and that I have withheld no information. I understand that misrepresentation, falsification of documents, or withholding of requested information regarding this application are serious offences and may result in prosecution under the University's Codes of Behavior and/or Criminal Code of California.

Student Signature: _____ **Date**:_____

FOR OFFICE USE ONLY

Chief Clinic Officer: _____ **Date**:_____

Please submit this form via e-mail to clinic.education@dula.edu.

Updated 10/01/2025