Application for Permission to Elect
CECP 6030 – Tests/Measurements

Return this form to CECP Administrative Assistant Elizabeth Schab via email at elizabeth.schab@wmich.edu.

Course CRN #:_____

Semester _____

Today's Date: _____

Student Name _____

Address_____

City_____ State _____ Zip code _____

WIN# _____

Program:

- ☐ **Clinical Mental Health Counseling—M.A.**
- ☐ **Counseling Psychology—M.A.**
- ☐ **Marriage Couple Family Counseling—M.A.**
- ☐ **Rehabilitation Counseling (Generalist) and Rehabilitation Counseling/Teaching (concentration in Blindness and Low Vision)—M.A.**
- ☐ **School Counseling—M.A.**

Advisor: _____

Total Credit Hours completed in your CECP program to date: _____

Current # enrolled hours: _____