Permission to Record

NEW YORK TECH *School of Health Professions*

Department of Physician Assistant Studies
Permission to Record Lectures

Semester: ☐ Fall ☐ Spring Year: _____

Course Name: _____

Course Number:_____

Student: _____

Student's Graduating Year: _____

Purpose: _____
_____
_____
_____

Instructor Name: _____

Instructor Signature: _____ Date:_____