UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

Registrar's Office

Transfer Credit Request Form

Name:_____ Student ID #:_____

Trimester/Year Enrolled:_____ Program Director Name:_____

Program:_____ Location:_____

Course Title and Course # to be transferred:_____ Credits:_____

Institution where course was taken:_____

Date when course was taken:_____

University of St. Augustine course to be credited:_____

Provide a brief description of the course(s) you are requesting be considered for transfer credit. For each course, you must attach transcript showing completed course, a syllabus and/or a course description and outline (if not included in the syllabus). Attach additional page(s), if necessary. **Please note: Transfer of graduate credits is limited to a maximum of 15% of the degree program. Transfer credit <u>will not</u> be approved for undergraduate coursework. One course per form. For more information regarding transfer credit please see the student handbook.**

_____

_____

_____

_____

_____ _____

Student Signature Date

Official Use

Approved:_____ Not Approved:_____ If Approved # of credits: _____

Recommendation/Comments:_____

_____

_____ _____

Instructor Signature Date

_____ _____

Program Director Signature Date

Registrar's Office

*$75.00 Transfer Review Fee Paid:_____ Date Paid:_____

*per course

_____ _____

Registrar Signature Date

Date Student Notified:_____