STATE UNIVERSITY OF NEW YORK HEALTH SCIENCE CENTER AT BROOKLYN
OFFICE OF THE REGISTRAR
BASIC SCIENCE BUILDING 1-112 BOX 98

REQUEST FOR ACADEMIC PROGRAM TRANSFER

COLLEGE OF HEALTH RELATED PROFESSIONS COLLEGE OF NURSING

TO BE FILLED OUT BY STUDENT

NAME: _____ ID # _____

ADDRESS: _____ COLLEGE: ❒ CHRP ❒ NURSING
STREET

_____
CITY STATE ZIP

REQUEST TO CHANGE TO
NEW PROGRAM : _____ FROM
CURRENT PROGRAM: _____

_____ _____
STUDENT SIGNATURE DATE OF REQUEST

ACCEPTANCE TO NEW ACADEMIC PROGRAM

PROGRAM: _____

PROGRAM CHAIR: _____
OR DEAN PRINT NAME

_____
PROGRAM CHAIR OR DEAN SIGNATURE DATE

EFFECTIVE SEMESTER: _____

ANTICIPATED DATE OF GRADUATION ____/____/____

CURRENT ACADEMIC PROGRAM ACKNOWLEDGEMENT

PROGRAM: _____

PROGRAM CHAIR: _____
OR DEAN PRINT NAME

_____
PROGRAM CHAIR OR DEAN SIGNATURE DATE

EFFECTIVE SEMESTER: _____

CURRENT PROGRAM CREDITS ACCEPTED FOR NEW PROGRAM REQUIREMENTS

DEPT & COURSE #	CREDITS	TITLE	DEPT & COURSE #	CREDITS	TITLE

_____ _____
NEW PROGRAM CHAIR OR DEAN SIGNATURE APPROVING CREDITS DATE

FOR OFFICE OF THE REGISTRAR USE ONLY
CHANGE ENTERED ON DATABASE ____/____/____ CREDITS POSTED ____/____/____ STAFF INITIALS _____

ORIGINAL – REGISTRAR STUDENT – YELLOW NEW PROGRAM – BLUE FORMER PROGRAM – GREEN 2/98