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

REQUEST FOR ACADEMIC PROGRAM TRANSFER

COLLEGE OF HEALTH RELATED PROFESSIONS/ SCHOOL OF PUBLIC HEALTH

TO BE FILLED OUT BY STUDENT

NAME: _____ ID # _____

ADDRESS: _____ COLLEGE: CHRP ____ Public Health ____
STREET

_____
CITY STATE ZIP

REQUEST TO CHANGE TO
NEW PROGRAM/TRACK: _____

FROM
CURRENT PROGRAM/TRACK: _____

_____ _____
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

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 _____

4/14