

Petition for the Transfer of Courses

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name: | Enter text. | URID: | Enter text. |
|  |  |  |  |
| Program: | Choose program | Date: | MM/DD/YYYY |

***Instructions:*** *Read the instructions document regarding the criteria and procedures for transferring credit to the SMD. The completed form, with appropriate initials should be submitted to* [*registrar@rochester.edu*](mailto:registrar@rochester.edu)*. A course description, course syllabus and* ***official transcript*** *with course highlighted should be included.*

***Guidelines for Transfer Credit:***

* *Course must be at the graduate level. Undergraduate courses are not eligible for transfer.*
* *Course must be completed within 5 years of the date of matriculation.*
* *Course must be an integral part of the proposed program of study.*
* *A grade of B or higher must be received.*
* ***A maximum of the following credits will be accepted for transfer: 30 credits for PhD, 10 credits for MA/MPH/MS, and 4 credits for CAS.***

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| --- | --- | --- | --- | --- |
| **Course(s) Taken or to be Taken at Other Institution(s)** | | | | |
| **Course #** | **Title** | | **Credits** | |
| Course | Title | | Credits | |
| Course | Title | | Credits | |
| Course | Title | | Credits | |
| **School of Medicine and Dentistry Equivalent** | | | | |
| **Course #** | **Title** | | **Credits** | |
| Course | Title | | Credits | |
| Course | Title | | Credits | |
| Course | Title | | Credits | |
| **Course Director Approval** | | | | |
| **Approved** | | **Course Director Name** | | **Initials** |
| Yes  No | | Director name | |  |
| Yes  No | | Director name | |  |
| Yes  No | | Director name | |  |

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| --- |
| Comments |
|  |
| Program Director Signature Date |

**Submit to** [registrar@rochester.edu](mailto:registrar@rochester.edu)