UNIVERSITY of VIRGINIA | SCHOOL of MEDICINE

SCHOOL of MEDICINE REGISTRAR
Office of Student Affairs
PO Box 800739
434-924-5200

APPLICATION FOR TRANSFER CREDIT

Student Name: _____ **SIS ID (7 digits):** _____
Last, First, Middle Initial (Print)

Degree Program: (Please select) _____

Enter graduate/professional courses from other institutions for which you wish to receive transfer credit. Only courses with a "B" grade or better may be used for transfer credit. Please attach a letter from the Director of Graduate Studies and a copy of the transcript(s) on which these courses appear.

Non-UVA Mnemonic & Number	Non-UVA Course Name	Credit granting Institution	# Credits granted by institution	Grade earned	UVA Mneumonic & Number	UVA Course Name	Credits for UVA course

The department approves ____ total transfer credit hours (maximum 24).

_____ _____ _____
Director of Graduate Studies (Print) *Signature* *Date*

_____ _____ _____
Associate or Assistant Dean (Print) *Signature* *Date*