

DIVISION OF GRADUATE MEDICAL SCIENCES
 BOSTON UNIVERSITY SCHOOL OF MEDICINE
 Room L-315

Petition for Approval of Credits for Transfer

INSTRUCTIONS: The attention of the student is called to the regulations on transfer of credit in the Division of Graduate Medical Sciences Bulletin. A student should file a separate set of forms for each institution from which transfer of credit is requested. Items 1 through 12 must be completed. Please print legibly using a ballpoint pen or typewriter. Submit this set of forms directly to the Division Office and request official transcripts of course work at other institutions be sent to: Petitions Coordinator, Division of Graduate Medical Sciences, Boston University School of Medicine, Room L-315, 715 Albany Street, Boston, MA 02118.

1. Name _____ 2. BU ID # _____
Last First Initial

3. Local address _____

4. Current degree program M.A. M.S. Post-bachelor's Ph.D. Post-master's Ph.D.

5. Department/Program _____ 6. Date entered _____

7. Major advisor's name _____

8. Institution from which credits are to be transferred: College or University _____
 Department or Program _____

9. Degree(s) earned (if any) and date(s) awarded _____

10. Have any of the courses listed below been applied to satisfy requirements for any degree previously earned?
 No Yes If yes, list course numbers _____

11. Specify below the curricular schedule in effect at the above institution at the time course work requested for transfer was taken:
 2-semester academic year 3-semester academic year 4-quarter academic year summer session (minimum 6 weeks) Other _____

12. LIST COURSES BELOW. BE SURE COURSE AND TITLES ARE EXACT. IN THE COLUMN MARKED "GRAD" PLACE A "G" NEXT TO ALL COURSES SPECIFICALLY DESIGNATED AS GRADUATE COURSES.

Academic year and semester or quarter	Course number	G R A D	Official Course Title	Instructor	__ Sem. Hours or __ Qtr. Hours	Grade
TOTAL NUMBER OF HOURS						

Major Advisor _____ Approved
Not Approved
Signature and Date

Department Chairperson/Program Director _____ Approved
Not Approved
Signature and Date

Associate Dean, Division of Graduate Medical Sciences _____ Approved
Not Approved
Signature and Date

Graduate School records: Received from Department/Program _____