HEALTH SCIENCES
INTRAUNIVERSITY TRANSFER APPLICATION

COMPLETED APPLICATIONS SHOULD BE RETURNED TO STUDENT SERVICES ROWELL 106

(If your transfer is denied this semester, you must notify our office to reactivate this application for subsequent semesters.)

Date _____ SSN: _____

Name: _____
Last First MI

Local Address: _____

Phone: _____ E-mail: _____

Permanent Address: _____

Phone: _____Current College & Year: _____

Current GPA: _____ Semester/Year Applying for: _____

Major Applying for: _____

Comments: _____

_____

_____

_____

I give the Admission and Academic Standards Committee permission to review my university record.

Date: _____ Signature: _____

For office use only

Approved _____ Deferred _____ Denied _____

Spoke to _____

Advisor: _____ Chair's Signature _____

7/02//cd