

KANSAS COLLEGE OF CHINESE MEDICINE

SUMMARY SHEET OF PROFESSIONAL COLLEGES AND TRAINING REQUEST FOR TRANSFER CREDIT

NAME:		SSN:	
ADDRESS:			DATE:
			PHONE NO:
KCCM PROGRAM:		START DATE:	
		ESTIMATED GRADUATION DATE:	

SEMESTER ATTENDED	TOT C/H	TOT CL/H & LAB	GRADE	TRANSFER COURSE TITLE & NUMBER	COLLEGE ATTENDED	KCCM COURSE TITLE & NUMBER	KCCM CL/H C/H	REF PG

I HEREBY SUBMIT MY REQUEST TO TRANSFER THE ABOVE NOTED COURSE _____ CREDIT HOURS/ _____ CLASS HOURS TO MEET MY KCCM COURSE REQUIREMENTS FOR THE MASTER OF ORIENTAL MEDICINE PROGRAM AND/OR THE DIPLOMA OF ORIENTAL BODYWORK PROGRAM. ALL COURSES REQUESTED FOR TRANSFER ARE REFLECTED ON THE OFFICIAL TRANSCRIPT(S) IN MY STUDENT FILE.

TRANSFER ACCEPTANCE

 STUDENT SIGNATURE DATE ACADEMIC DEAN SIGNATURE DATE

Legend:
 C/H=Credit Hours
 CL/H=Class Hours
 Tot=Total