



Doctoral Transfer Credit Approval Form Springfield College

*Office of the Registrar
263 Alden Street
Springfield, MA 01109-3797
Phone (413) 748-3530*

Student Name: _____ Student I.D. : _____

Major/Program of Study: _____ Advisor: _____

Semester/Year Matriculated: _____ Expected Date of Graduation: _____

DESCRIPTION OF COURSE(S) MUST ACCOMPANY THIS FORM :

- ❖ Course(s) must be taken at a regionally accredited institution of higher education
- ❖ See catalog for details for transfer credit for Doctoral programs
- ❖ Course(s) must be taken for letter graded, college credit. A minimum grade of “B“is required
- ❖ Grades received are not indicated on the SC record
- ❖ A student may not receive duplicate credit for a course already taken
- ❖ This form is required for work coming from any college/university including Springfield College

Credit Hours Completed To Date: _____ # of Transfer Credits previously awarded: _____

College/Univ: _____	Sem/Year: _____
Dept: _____ Course #: _____ Title: _____	Credits: _____
<i>(OFFICE USE ONLY)</i> Comments: _____	

SC Course Equivalency: _____	Dept Chair / signature: _____

College/Univ: _____	Sem/Year: _____
Dept: _____ Course #: _____ Title: _____	Credits: _____
<i>(OFFICE USE ONLY)</i> Comments: _____	

SC Course Equivalency: _____	Dept Chair / signature: _____

College/Univ: _____	Sem/Year: _____
Dept: _____ Course #: _____ Title: _____	Credits: _____
<i>(OFFICE USE ONLY)</i> Comments: _____	

SC Course Equivalency: _____	Dept Chair / signature: _____

Student Signature

Date

Advisor's Signature

Date

Department Chair

Date

Registrar's Signature

Date



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Dept: _____ Course #: _____ Title: _____ Credits: _____
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Student Signature

Date

Advisor's Signature

Date

Department Chair

Date

Registrar's Signature

Date