

**THE UT-MD ANDERSON SCHOOL OF HEALTH SCIENCES
PETITION FOR EQUIVALENCY CREDIT**

(Documents that may be submitted: Syllabus: Course Description, Objectives, Content Outline, Class Schedule; Handouts, Class Notes, Assigned Papers, Care Plans, etc.; Textbook)

Student name: _____ Student SSN# _____

Date: _____ Daytime phone or pager _____

Program: Cytogenetics _____ Cytotechnology _____ Diagnostic Imaging _____ Histotechnology _____ Medical
Dosimetry _____ Medical Technology _____ Molecular Genetics _____ Radiation Therapy _____

I REQUEST EQUIVALENCY CREDIT FOR UT MD ANDERSON COURSE:

Course #	Title of Course	Cr. Hrs.

TRANSFERRING SCHOOL: _____

Course #	Title of Course	Cr. Hrs.	Grade	Date Completed

**** After completing the upper portion, return this page to your Program Director. ****

FOR OFFICE USE ONLY . . .

FULL APPROVAL _____ **PARTIAL APPROVAL** _____ **DENIED** _____
Credits

Signature of Faculty Member Reviewing Course Date

Signature of Program Director Date

Comments:

