Washington University in St. Louis
SCHOOL OF MEDICINE

TRANSFER CREDIT FORM

This form should be completed and submitted to the School of Medicine Registrar's Office at wusmregistrar@wustl.edu.

Student Name: _____ **Student ID:** _____

Program Name: _____

Name of Institution: _____ **Number of Credits:** _____

Please attach a copy of the official transcript with courses/credits to be transferred clearly marked.

_____ _____

Submitted by (name) Date

Comments:

Updated 9/16/2022