

El Centro College Associate Degree Nursing Program Request for Campus/Facility Transfer

Student Name _____ ID No. _____

Address _____

Street Address

Apt.

City

State

Zip Code

Telephone _____

Home

Work

Cell/Other

Email _____

Last Nursing Level Successfully Completed: _____ RNSG 1423 (J1) _____ RNSG 2514 (S1)
(check one)

_____ RNSG 2504 (J2) _____ RNSG 2535 (S2)

Semester/Year of Desired Transfer: Fall 20_____ Spring 20_____

Current Campus/Facility _____

I wish to transfer to (Campus/Facility): _____

Reasons for Transfer Request (Please print or type): _____

I understand that approval of a transfer request from one campus/facility to another is at the discretion of the Health and Legal Studies Division administration in cooperation with the Health Occupations Admissions Office and is based upon space availability. **I further understand that I may be granted a transfer only one time during the nursing program.** I also acknowledge that my request for transfer may not be granted.

Student Signature _____ Date _____

Transfer Approved _____ Date _____
Health/Legal Studies Division Signature

Transfer Denied _____ Date _____
Health/Legal Studies Division Signature