RUTGERS HEALTH
School of Public Health

Office of Admissions
Rutgers, The State University of New Jersey
683 Hoes Lane West, Room 110
Piscataway, NJ 08854

sph.rutgers.edu
admissions@sph.rutgers.edu
p. (732) 235-4646

Request for Program Degree Transfer

This form should be used to request an official transfer to a different degree within the School of Public Health. The Admissions Committee will review the student's original admission file, as well as the student's School of Public Health transcript, in order to make a decision regarding the transfer request.

1. **Name:** _____
   Last Name *First Name* *Middle Initial*

2. **Student ID:** _____

3. **Rutgers Email Address:** _____

4. **Phone Numbers:**
   _____
   Home Telephone Number (incl. area code) *Business Telephone Number (incl. area code)* *Mobile Telephone Number (incl. area code)*

5. **Semester Transfer to Take Effect:** ❑ **Fall** ❑ **Spring** ❑ **Summer** **Year** _____

6. **Current Location:** *(please check one)* ❑ **New Brunswick** ❑ **Newark** ❑ **Online**

7. **Current Degree Program:** *(please check one)* ❑ **MPH** ❑ **MS-Biostatistics** ❑ **MS-Epidemiology** ❑ **MS-HOPE** ❑ **DrPH** ❑ **PhD**

8. **Requested Location for Transfer:** *(please check one)* ❑ **New Brunswick** ❑ **Newark** ❑ **Online**

9. **Requested Program for Transfer:** *(please check one)* ❑ **Certificate** ❑ **MPH** ❑ **MPH Option for Clinicians*** *See Item #11 below.* ❑ **MS-Biostatistics** ❑ **MS-Epidemiology** ❑ **MS-HOPE** ❑ **DrPH** ❑ **PhD**

   If Certificate program, please specify which certificate: _____

10. **Concentration in which Student is Seeking Entrance:** _____
    (Leave blank if requesting transfer to a Certificate program or MS-HOPE degree.)

11. ***(Complete if requesting transfer into the MPH Option for Clinicians only):***

    I understand the Eligibility Requirements for the MPH Option for Clinicians: *(please check one)* ❑ **Yes** ❑ **No**
    To be eligible for the MPH Option for Clinicians, students must be currently licensed as a "health care provider" in a U.S. state or territory -AND- be performing within the scope of their practice as defined by State law. A copy of the license and workplace verification must accompany this form. Health care providers include: doctor of medicine or osteopathy, podiatrist, dentist, physician assistant, chiropractor, psychologist, optometrist, nurse practitioner, nurse-midwife, pharmacist, registered dietician, social worker or licensed professional counselor or therapist who is authorized to practice by a State.

    I have met with and provided ALL of my documentation regarding my eligibility to the Office for Admissions: *(please check one)* ❑ **Yes** ❑ **No**

_____
Student Signature Date

_____
Current Academic Advisor Date

_____
Department Chair/Vice-Chair/Concentration/Program Director/Leader Signature (of new program) Date

_____
Department Chair/Vice-Chair/Concentration/Program Director/Leader Signature (of original program) Date

_____
Assistant Dean for Admissions and Recruitment Signature Date

RETURN TO OFFICE OF ADMISSIONS

Copies to:
Office of Admissions
Office of the Registrar
Program of Origin
Program of Transfer
Academic Advisor
Student