AUGUSTA UNIVERSITY

Office of the Registrar
Summerville Campus-Rains Hall
1120 15th Street
Augusta, GA 30912
706-446-1430
Registrar@augusta.edu

CAMPUS TRANSFER REQUEST FORM

PLEASE COMPLETE AND RETURN THIS FORM TO THE REGISTRAR'S OFFICE

STUDENT ID # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

NAME: _____ _____ _____
LAST FIRST MIDDLE/MAIDEN

MAILING ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

SCHOOL: ☐ CAHS ☐ COGS ☐ MCG ☐ CON

DEPARTMENT _____ DEGREE PROGRAM _____

STUDENT STATUS: ACCEPTED APPLICANT _____ CURRENTLY ENROLLED STUDENT ____

CURRENT TERM & YEAR: FALL ____ ____ SPRING ____ ____ SUMMER ____ ____

PERMISSION IS HEREBY REQUESTED TO TRANSFER FROM _____ TO _____
CURRENT CAMPUS NEW CAMPUS

EFFECTIVE DATE _____ EFFECTIVE SEMESTER _____
MONTH DAY YEAR TERM & YEAR

REASON FOR TRANSFER _____

DEPARTMENT APPROVAL _____ DATE _____
(TWO SIGNATURES REQUIRED FOR ALL GRADUATE PROGRAMS)
DEPARTMENT CHAIR CAHS - ASSOCIATE DEAN CON

_____ DATE _____
ASSOCIATE DEAN COGS / DEAN COGS - ASSOCIATE DEAN MCG

REGISTRAR'S APPROVAL _____ DATE _____
ASSOCIATE REGISTRAR / REGISTRAR

PROCESSED BY & DATE _____