

Credit Evaluation Request

Complete this form and return it to the Educational Planner for Allied Health (*mail: 1300 Fifth Street, Wenatchee, WA 98801 or email: nfortner@wvc.edu*). Please <u>allow up to 4 weeks for the evaluation</u> to be completed and returned. **This evaluation does not replace program applications.**

Program of Interest					
☐ Medical Assis	☐ Medical Assistant				
 ☐ Medical Laboratory Technology ☐ Check this box if you have a bachelor's degree 					
□ <u>Nursing</u> □ <i>Check</i>	this box if you are a	currently licensed	LPN		
☐ <u>Radiologic Te</u>	<u>chnology</u>				
Contact Information					
Full Legal Name _			Former Name		
WVC Student ID _			Birth Date		
Would you like you	-	-	via mail or email?		
Mailing Address	ı mun	□ Email			
Walling Address _	Number & Street (Include Apartment Number)				
_	City		State	Zip	
Email Address _	Disclaimer: ema	il is considered to be an insec	ure means of transmitting prote	ected information under FERPA.	
Telephone _	Day		Evening		
Academic History					
List <u>ALL</u> colleges/univ	versities you've at	tended <u>AND</u> attac	ch official/unofficia	al copies of your transcripts:	
Student Signature (required)			Date	

You must sign this by hand. A typed signature will **NOT** suffice.