

MINNESOTA TRANSFER CURRICULUM COMPLETION REQUEST

OFFICE OF RECORDS AND REGISTRATION
St. Cloud State University
720 4th Avenue South
St. Cloud, Minnesota 56301-4498

Student Information

Student Name _____ SCSU ID _____

Address _____

Day Phone () _____ SCSU Email _____

Completion Term: Fall Spring Summer Year _____

Student Signature: _____ DATE ____/____/____

Advisor Signature: _____ DATE ____/____/____