



**CITY COLLEGES OF CHICAGO REVERSE ARTICULATION
TRANSCRIPT REQUEST FORM**

Office of the Registrar
1200 W Harrison St
1200 SSB, MC 018
Chicago, IL 60607

Complete and Sign form - Return to the Office of the Registrar

Records@uic.edu

Please read and complete the form with the appropriate information. This form should be used only when ordering transcripts to complete a request for a reverse articulation of UIC credit to be considered for a CCC Associate's Degree.

Student Information (All information is required to identify your record-please write clearly)

UNIVERSITY ID	SOCIAL SECURITY NUMBER (optional)	DATE OF BIRTH (mm/dd/yyyy)	PHONE #	
FULL NAME (Last, First, Middle)				
MAIDEN/OTHER NAME (Last, First, Middle)				
FORMER NAMES USED OR NAMES WHILE STUDYING AT UIC				
CURRENT ADDRESS - Street	APT.	CITY	STATE	ZIP CODE
UIC DATES ATTENDED or Degree(s) and Date(s) Awarded				

REVERSE TRANSFER OF CREDIT PROGRAM REQUIREMENTS

A minimum of 15 semester credit hours earned at the City Colleges of Chicago (CCC), and a minimum of 45 transferable semester credit hours earned.

DEGREE COMPLETION INFORMATION

Please note, you will be considered for the degree you last pursued on record at the City Colleges of Chicago. To qualify for an Associate Degree, students must earn a grade of "C" or better in all courses used to satisfy core curriculum and general education degree requirements and hold a minimum graduation GPA of 2.0 at CCC.

An audit of completed coursework at the City Colleges of Chicago, and transferable courses will be conducted. Only coursework that fulfills the graduation requirements will be considered for the degree. If credit includes hours earned at other accredited colleges, an official transcript from each institution must be submitted with this application. CCC must receive all student transcripts with this application to be considered for the Reverse Transfer of Credit.

In accordance with the Family Education Rights and Privacy Act of 1974 (**FERPA**), your records will only be released with your consent.

Authorization Signature Required - *I authorize release of my transcripts to the City Colleges of Chicago as directed on this form. No Electronic signatures.*

X _____

Date _____

**Destination
Mailing Address:**

**Alfredo Estrada
District Director - Student Transfer Systems
Office of Transfer and Articulation
226 West Jackson, Room 1304
Chicago, IL 60606**

OFFICE USE ONLY

Enc: Y N Date _____

Prepared by _____ Date _____