FACULTY OF HEALTH SCIENCES
ASSESMENT OF COURSES FOR EQUIVALENCY

TO BE FILLED OUT BY THE STUDENT:

NAME		TELEPHONE NUMBER
STUDENT NUMBER	PROGRAM OF STUDIES	DATE

INFORMATION CONCERNING COURSE COMPLETED AT OTHER INSTITUTION						
INSTITUTION	COURSE CODE AND TITLE	# OF CREDITS	YEAR ATTENDED	GRADE RECEIVED	COURSE CODE (U. of O.) CODE	CREDITS

Number of hours of lecture:	Texts used:
Number of hours of clinical:	Method of evaluation (exams, assignments, etc.):
Number of hours of lab:	Qualifications of teacher (B.ScN., M.Sc.N., Ph.D., etc.):

FOR FACULTY USE:

To:	From:

COMMENT OF REVIEWER:	(Please review course for equivalency as to course objectives, content, methodology and evaluation, and return all documents with your comments.)

Date:	Signature: