Merced College
Allied Health
Diagnostic Medical Sonography Program

Name: _____ **Student ID #:** _____

Equivalency Verification Form

If you completed all prerequisite classes at Merced College or your classes are listed on the Grid of **Comparable Prerequisite Courses** you **do not need** to complete this form, nor do you need a counselor's signature.

If your course is NOT listed on the **Comparable Prerequisite Courses**, submit your Official transcript(s) from other colleges/universities directly to the Merced College Admissions & Records office by the deadline posted on the **DMS Program website**. After your courses have been evaluated, make an appointment with an ALLIED HEALTH Counselor to verify equivalency. Call 209-381-6478 or email **ecounselor@mccd.edu** to book an appointment.

Fill this form out for the course(s) you need verified for equivalency.

- Write "n/a" for courses shown on your Merced College Transcript.
- Write "n/a" for courses listed on the Grid of Comparable Prerequisite Courses.

Prerequisite	College/ University	Course Name & Number (ex. BIOL-20)	Course Unit Value	Semester & Year	Counselor **Initial** verifying equivalency	Course Grade
ALLH-67 Medical Terminology						
BIOL-16 General Human Anatomy						
BIOL-18 - Principles of Physiology						
ENGL-1A - College Composition & Reading **or** COMM-1 – Fundamentals of Speech						
MATH-26 **or** MATH-25 **or** MATH 15 **or** MATH-10 **or** Equivalent course (or higher Math course)						
PHYS-10 – Concepts in Physics **or** *****RADT-13 – Radiologic Sciences (*****course is only offered to **accepted** student in the Merced College Diagnostic Radiologic Technology Program)						

I have read the instructions outlined on this page. My application may be denied pending further department evaluation.

Failure to complete & SIGN form will lead to your application being disqualified.

Applicant Signature: _____ **Date:** _____

Merced College Allied Health Counselor

- ◯ CID Number
- ◯ HECCC Nursing Degree Admission Grid
- ◯ Merced College Internal Evaluation on File
- ◯ Based on Initial Counselor Assessment

Rationale for temporary approval: _____

_____

Print Name: _____

Signature: _____ Date: _____