



CREDIT BY EXAMINATION FORM

Student may challenge select courses by taking examinations developed at CDU. Credit shall be awarded to those who pass the examination successfully.

Last Name: _____ First: _____ MI: ____ Date: _____

Telephone No: (____) _____ Student Email Address: _____

Program of Study: _____ Student ID: _____

EXAMINATION INFORMATION

Semester:

Semester	Exam Dates	Last Day To Register & Pay
<input type="checkbox"/> SPRING 2026	January 6 – January 8	January 5, 2026
<input type="checkbox"/> SUMMER 2026	May 12 – May 14	May 8, 2026
<input type="checkbox"/> FALL 2026	August 4 – August 6	July 31, 2026
<input type="checkbox"/> SPRING 2027	January 5 – January 7	January 4, 2027

I am requesting to take the exam for:

Course: _____ Course Title: _____ Course Units: _____

Students will have 2 hours to complete the exam from the time they begin.

Eligibility Requirements: (Complete with Advisor)

Student is currently enrolled at CDU? Yes No

Student has not previously attempted the course at CDU? Yes No

Student is in good academic standing (minimum cumulative G.P.A. of 2.00)? Yes No

Has the student previously earned units by Credit by Exam? Yes No If Yes, How Many? _____

Maximum Credit by Exam Units: Certificate Programs: 3 Units. Associates Programs: 6 Units, Bachelors Programs: 9 Units

I understand that by signing this form, that I agree to pay the examination fee if I am approved to take the exam. I further understand that I will not be permitted to take the exam if the fee is not paid by the deadline for the selected exam period. Lastly, I understand that I can only attempt this exam once. If I pass the exam, I understand I will receive credits for passing the exam but will not receive a letter grade that counts towards my GPA. If I fail the exam, I understand I will need to take the course in order to receive credit. There is no refund for failed examination attempts.

Student Signature _____ Date: _____

Faculty/Department Review

Final Score: **CR:** Student has successfully passed the exam. **NCR:** Student has not passed the exam.

Faculty Name: _____ Signature: _____ Date: _____

Faculty must submit final score to the Office of Registration and Records via email at registrar@cdrewu.edu

Office of Registration and Records

Examination Fee (\$50.00) Paid: Yes Payment Date: _____

Final Score Posted in PC: Posted By: _____ Date: _____