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
☐FALL 2026	August 4 - August 6	July 31, 2026
☐SPRING 2027	January 5 - January 7	January 4, 2027
☐SUMMER 2027	May 11 - May 13	May 7, 2027
☐FALL 2027	August 17 - August 19	August 13, 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 the Registrar via email at registrar@cdrewu.edu

Office of the Registrar

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

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