

American University of Complementary Medicine

REGISTRATION FORM

Part 1

_____ Spring _____ Summer

_____ New Student

_____ Fall 20_____

_____ Continuing

Please fill in **ALL** spaces, even if you have provided this information previously.
Students must also complete Registration Form - Part 2

_____ New Address

Date: _____ Name: _____ ID # _____

Address: _____ City: _____ Zip: _____

Telephone: H: (____) _____ C: (____) _____ W: (____) _____

Fax: (____) _____ Email address: _____

Course #	Course Title	Units	Start/End Date	Instructor	Tuition

Student Tuition Recovery Fund = \$2.50 for up to and per \$1,000 of Tuition:	Tuition Total:	
	STRF Total:	
	Late Fee:	
	Adjustments:	
	Total Due:	

Agreement is made this date between the above-named student, hereinafter referred to as the "student" and the American University of Complementary Medicine. Under this agreement, the student engages the University to provide educational services under terms and conditions as published in the University's printed materials describing course offerings, regulations, tuitions and fees; including, but not limited to the University CATALOG and STUDENT HANDBOOK.

My signature below certifies that I have read, understood, and agreed to my rights and responsibilities, and that the institution's cancellation and refund policies have been clearly explained to me.

Student Signature: _____ Date: _____

Registrar: _____ Date: _____