



# SOUTH BAYLO UNIVERSITY

1126 N. Brookhurst Street, Anaheim, CA 92801 TEL: 714-533-1495 FAX: 714-533-6040 WEB: www.southbaylo.edu

## Doctor of Acupuncture and Oriental Medicine

### REGISTRATION FORM

This registration form is a formal agreement. You will be billed from this agreement and assigned to the class rosters as indicated. Any revisions to this registration must be made with an official "Add/Drop" Form. Keep a copy for verification.

Student Name: \_\_\_\_\_ Student ID #: \_\_\_\_\_

Telephone No. \_\_\_\_\_ Year \_\_\_\_\_ Quarter \_\_\_\_\_

Course No.	AN/LA	Course Title	Day	Time	Units

#### CLERKSHIP

Course No.	AN/LA	Course Title	Day	Time	Hours

Number of Units Enrolled \_\_\_\_\_ Units X \$ \_\_\_\_\_ per unit = \$ \_\_\_\_\_

Registration Fee : \$ \_\_\_\_\_

Hours of Clerkship enrolled \_\_\_\_\_ Hours X \$ \_\_\_\_\_ per unit = \$ \_\_\_\_\_

Other (please specify): \_\_\_\_\_ \$ \_\_\_\_\_

Other (please specify): \_\_\_\_\_ \$ \_\_\_\_\_

Total Amount to Pay \$ \_\_\_\_\_

Paid \$ \_\_\_\_\_

Balance \$ \_\_\_\_\_

CHECK # \_\_\_\_\_ CASH \_\_\_\_\_ CREDIT CARD \_\_\_\_\_ RECEIPT # \_\_\_\_\_

My signature below certifies that I have read, understood, and agreed to my rights and responsibilities, and that SBU's cancellation and refund policies have been clearly explained to me. I also certify that I have read and understood the Doctorate degree requirements for graduation.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctoral Program Advisor \_\_\_\_\_ Date \_\_\_\_\_