Southern California University

School of Oriental Medicine and Acupuncture
1541 Wilshire Blvd., 3rd Fl.
Los Angeles, CA 90070
Tel: 213-413-9522 Fax: 213-413-5400

Registration Form

Quarter:☐Winter ☐Spring ☐Summer ☐Fall 20__

Name: _____
Last First Middle

Student ID#: _____

Address: _____
Street Apt#

S.S.#: _____

_____ Home Phone#:_____–_____–_____
City State Zip Code

Work Phone#:_____–_____–_____

☐ Check if address changed

Course #	Course Name	Day	Instructor	Units/ Hrs

Student Signature: _____ Date: _____

Registrar's Signature: _____ Date: _____

Clinic Director's Signature: _____ Date: _____

Office Use Only

FEES: Student Association Fee: $_____ Others: $_____
Malpractice Insurance Fee: $_____ Others: $_____ Total Fees: $_____

TUITION _____Units x $_____ = $_____
_____Units x $_____ = $_____
_____Hours x $_____ = $_____ Total Fees: $_____

PAYMENT: (Minimum 1/3 of tuition due at registration)
1st installment: $_____ Receipt#: _____
2nd installment: $_____ Due Date _____
3rd installment: $_____ Due Date _____

Handled by: _____ Date: _____

Rev.11/2004