# UNIVERSITY OF COLORADO DENVER – ANSCHUTZ MEDICAL CAMPUS
# STUDENT REGISTRATION

STUDENT NUMBER:_____ TERM:_____

LAST NAME: FIRST NAME: MIDDLE/MAIDEN:

CURRENT ADDRESS:
No. and Street: City: State: Zip: Telephone:

Check one: COLORADO RESIDENT_____
NONRESIDENT_____
WICHE, WUE, WGRP_____
If non-Colorado resident or WICHE, WUE, WGRP indicate state of residency_____

COUNTRY OF CITIZENSHIP: _____
If country of citizenship not U.S.A., indicate visa type _____

---

**INDICATE PROGRAM:**

_____Child Health Assoc/Physician Asst

_____Medicine (MSTP)

_____Other_____

**GRADUATE SCHOOL**
(Basic Sciences, Public Health)

_____M.S.

_____Ph.D.

Dept:_____ Lab Phone #_____

**PLEASE CHECK ONE**: _____Continuing student
_____New student

---

GRADUATING THIS TERM: _____Yes

**E-Mail Address**:_____

| DEPT ABBR | COURSE NUMBER | SECTION NUMBER | CREDIT HOURS | COURSE TITLE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **TOTAL CREDIT HOURS:** | | | | **PLEASE HAND DELIVER COMPLETED & SIGNED FORM TO AMC REGISTRAR'S OFFICE - Education 2 North, 3rd Floor** |

PROGRAM ADVISOR SIGNATURE:_____

DATE:_____

STUDENT SIGNATURE:_____

DATE:_____

COURSE DIRECTOR SIGNATURE: _____

DATE: _____

GRADUATE SCHOOL DEAN: _____
(If undergraduate student)

DATE: _____

Rev. 10/99