Alhambra Medical University

Administration Office: 2215 West Mission Rd., Suite 280, Alhambra, CA 91803
Tel: 626-289-7719 Fax: 626-289-8641

COURSE DROP FORM

Please use ink (No pencil)

NO. _____

Name: _____ Student ID: _____
Last(姓) First (名)

Quarter: ◯ Winter ◯ Spring ◯ Summer ◯ Fall Year: _____

Course No.	Course Title	Units	Day	Track	Instructor's Name
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Total Unit _____

Clinical Practice

Course No.	Clinic Course Title	Hours	Day	Supervisor's Name
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Total Hours: _____

Student Signature: _____ Date: _____

Clinic Director Signature: _____ Date: _____

Academic Dean Signature: _____ Date: _____

University Registrar Signature: _____ Date: _____

Office Use Only

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Tuition Credit / Refund

Courses $ _____ X _____ Units = _____

Clinic Hours $ _____ X _____ Hours = _____

Other Refund $ _____ **Total $** _____

Note: _____

Method of Credit: ☐ Credit to Account ☐ Refund Check

Handled by : _____ Date: _____

Revised: 01/2014