

# Alhambra Medical University

Administration Office: 2215 West Mission Rd., Suite 280, Alhambra, CA 91803

Tel: 626-289-7719 Fax: 626-289-8641

## COURSE ADD FORM

Please use ink (No pencil)

NO. \_\_\_\_\_

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

Last(姓) First(名)

Circle one: 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: \_\_\_\_\_

Univerisity Registrar Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Office Use Only

Tuition Charge:

Courses \$ \_\_\_\_\_ X \_\_\_\_\_ Units = \_\_\_\_\_

Clinic Hours \$ \_\_\_\_\_ X \_\_\_\_\_ Hours = \_\_\_\_\_

Other Charge \$ \_\_\_\_\_ Total \$ \_\_\_\_\_

Note: \_\_\_\_\_

Payment received \$ \_\_\_\_\_ Date: \_\_\_\_\_ Receipt # \_\_\_\_\_

Handled by : \_\_\_\_\_ Date: \_\_\_\_\_