

Registration Form

Office Use Only

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Fall 20____ Spring 20____ Summer 20____ Anticipated Graduation Date _____

Enter the number of the **program of study** from the list below: _____
Program of Study

NAME

Last Name First Name Middle Name

ADDRESS Is this address different from what you've previously given us? Yes No

Number and Street City State Zip Code

(____) _____
Home Phone: Area Code and Number

Social Security Number Date of Birth

Academic Programs

1. Allied Health Completion (BS)
 2. Clinical Laboratory Science (Certificate)
 3. Diagnostic Medical Sonography (AS)
 4. Emergency Medical Services (Certificate or AS)
 5. Health Care Administration (BS)
 6. Health Science (BS)
 7. Medical Assisting (Certificate or AS)
 8. Nuclear Medicine Technology (Certificate)
 9. Nursing (AS)
 10. Nursing Completion (BS)
 11. Physical Therapist Assistant (AS)
 12. Polysomnographic Technology (Certificate or AS)
 13. Radiologic Technology (AS)
 14. Surgical Technology (Certificate or AS)
- General**
15. Guest
 16. Liberal Arts and Science
 17. Short-term Certificate

Course No. - Section No.	Course Name	Credit Hours	M	T	W	R	F	S
Example: ENG 101 - 01A	English Composition I	3	1-1:50p.m.		1-1:50p.m.		1-1:50p.m.	

Total Credit Hours

Are you applying for tuition reimbursement from your employer? Yes No Are you a Mercy Employee? Yes No Are you a Mercy Scholar? Yes No

Student's Signature _____ Date _____

Advisor's Signature _____ Date _____

Date Processed _____ Registrar's Signature _____

8394600-052-4pt 04/09