



SOUTHERN CALIFORNIA UNIVERSITY

School of Oriental Medicine and Acupuncture

3460 Wilshire Blvd. 5th Fl. Los Angeles, CA 90010 • 213) 413-9500 • fax: 213) 413-5400 • info@scusoma.edu

Name: _____
 Last First Middle

Student ID # _____

Address: _____
 Street Apt#

Cell Phone# _____

 City State Zip Code

Quarter: Winter Spring Summer Fall 20__

REGISTRATION FORM

No.	Course No.	Course Name	Instructor	Day	Units
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

FEES

STUDENT ASSOCIATION FEE: \$ _____ HERB SAMPLE FEE: \$ _____ OTHER: \$ _____

MAL PRACTICE INSURANCE FEE: \$ _____ REGISTRATION FEE: \$ _____ **TOTAL FEES: \$ _____**

TUITION

TUITION: _____ UNITS X \$ _____ = \$ _____

_____ HOURS X \$ _____ = \$ _____ **TOTAL FEES: \$ _____**

TOTAL AMOUNT TO PAY \$ _____

PAYMENT: (minimum 1/3 of tuition due at registration)

1st installment: \$ _____

2nd installment: \$ _____

3rd installment: \$ _____

Student Signature: _____

Date: _____

Registrar's Signature: _____

Date: _____