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: _____ Student ID # _____
Last First Middle

Address: _____ Cell Phone# _____
Street Apt#

_____ Email Address: _____
City State Zip Code If Changed

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:** _____