Trinity College of Nursing
& Health Sciences
UnityPoint Health

Course Registration/Add/Drop Form

Fall Semester 20 _____ Spring Semester 20 _____ Summer Semester 20 _____

STUDENT NAME: (Top portion must be completed in its entirety.)

_____
(Student Last Name) (First Name) (Middle Name)

_____
(Address) (City, State) (ZIP)

Home Telephone: _____ Work Telephone: _____ Cell Phone: _____

Social Security# _____-_____-_____ Birthdate: _____-_____-_____

Student's E-mail Address: _____

CLASSIFICATION:

☐ AAS ☐ ASN ☐ BSHS ☐ BSN ☐ HCE ☐ MSN

COURSE NAME (i.e. Bio 145)	Check box if **"online"** course	**5-DIGIT COURSE NUMBER** *this must be present to process registration form	**SECTION NUMBER**	**SEMESTER HOURS**	**PROVIDING INSTITUTION** (TC, BHC, EICC, WIU)	**R** - Register **A** - Add **D** - Drop **WF** - Withdrawal Failing **WP** - Withdrawal Passing **AU** - Audit

Advisor Signature: _____ Date: _____

REFUND POLICY

It is very important to be aware of the Refund Policy. The Refund Policy varies by the institution in which the courses are offered, therefore students should check the Refund Policy for that institution.

I AUTHORIZE THE DEDUCTION OF ANY FINANCIAL ASSISTANCE TO PAY TUITION AND FEES FOR COURSES ON THIS REGISTRATION FORM. I REALIZE I MUST BE IN REGULAR CLASS ATTENDANCE TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE.

Your signature on the line below indicates that you have read and understood all of the information concerning registration and financial assistance. **This form will not be processed without a student signature.**

Student's Signature: _____ Date: _____

For Office Use only:

☐ Faxed

☐ Registered

☐ Billed

☐ Financial Aid