THE UNIVERSITY OF OKLAHOMA
HEALTH SCIENCES CENTER

Enrollment Form

Semester: _____ Year: _____

Name:	ID Number:
Current Address:	Permanent Address:
Current Telephone: ( )	Permanent Telephone: ( )
Date of Birth:	Marital Status: ☐ Married ☐ Single

College:	Major	Year in Program:

Expected Graduation Date:

Emergency Contact:	Emergency Telephone: ( )

Permission to release hard copy and online directory information: ☐ Yes ☐ No

The data above is correct and the schedule below lists my desired class enrollment for the semester indicated. Also, to cancel my enrollment, I must notify my advisor and complete the cancellation request prior to the first day of class.

Student Signature: _____ Date: _____

Advisor Signature: _____ Date: _____

DEPT	COURSE #	SEC #	HRS	COURSE TITLE	INSTRUCTOR

OFFICE USE ONLY: