

PLEASE INCLUDE

1) COMPLETED REGISTRATION FORM (WITH ALL APPROPRIATE SIGNATURES)

2) PAYMENT OF TUITION & FEES BY ONE OF THE FOLLOWING:

- **CREDIT CARD FORM***
(FOR PER CREDIT STUDENTS ONLY)
- **CHECK***
- **FINANCIAL AID**
(NOT APPLICABLE FOR THE SUMMER SEMESTER)
- **NYMC DEFERRED MONTHLY TUITION PAYMENT PLAN APPLICATION***
(NOT APPLICABLE FOR THE SUMMER SEMESTER)
- **TUITION REMISSION FORM***

****STUDENT MUST SUBMIT FEES WITH FORMS***

*(GSBMS \$5 Network Access/\$15 Student Activity/\$25 General Fee
SHSP \$25 Network Access/\$30 Student Activity)*

3) AFFILIATE LETTER (IF APPLICABLE)

4) NYMC EMPLOYEE TUITION FORM (IF APPLICABLE)

5) ADDRESS INFORMATION FORM



New York Medical College
Office of the University Registrar
 Sunshine Cottage
 Valhalla, NY 10595

Registration Form
 Page 1 of 2

Student ID _____ Last Name _____ First Name _____ Middle _____

Term: Fall Spring Summer **Year** _____ **Status:** Continuing New
School: Graduate School of Basic Medical Sciences School of Health Sciences & Practice
Degree(s): MS MPH DRPH DPT PHD MD Certificate Non Matriculated
Field(s): _____

Courses need prior approval by an advisor or program director.

Class No.	Catalog No.	Course Title	Credit(s)	Instructor's Signature
Total Credits				

Program Director's Signature

Dean's Signature (if applicable)

Registration Agreement:

I accept this program with full responsibility for the courses selected. I know that any course change must be authorized and that there is a fee. I am aware that no deduction in charges is made for temporary absence from classes, nor is any refund made if I am suspended, dismissed or leave the college for any reason. To WITHDRAW or make program changes I must submit the appropriate documentation to the Registrar's Office.

Student's Signature

Date

*** This form MUST be accompanied by correct payment and a completed Address Information form ***



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Registration Form
Page 2 of 2

Student ID _____

Last Name _____

First Name _____

Middle _____

Term: Fall Spring Summer **Year** _____

School: Graduate School of Basic Medical Sciences School of Health Sciences & Practice

Tuition Payment

Total Amount of Credits _____

- Credit Card (attach form)
- Check
- Financial Aid _____ (Financial Aid officer's signature is required)
- Tuition Payment Plan (attach form)

Tuition Benefits

- MD/MPH Payment Schedule
- MD/Certificate Payment Schedule
- PT/MPH Payment Schedule
- PHD Tuition Remission (attach form)
- NYMC Employee (attach form)
- Affiliate (attach letter)
- Other _____ (attach documentation)

Appropriate documentation must accompany your registration form.



New York Medical College

Address Information

School: School of Health Sciences & Practice
 Graduate School of Basic Medical Sciences

NYMC Employee? Yes No

If necessary, please submit changes to Emergency Contact information on the appropriate form.

Student ID Number _____ Last Name _____ First Name _____ Middle _____

<p>PERMANENT ADDRESS</p> <p><i>This is your primary residence or the permanent residence of your parents or guardian if you live at a local address during the academic year. Your NYMC mail is sent to this address if you do not have a separate mailing address.</i></p>	<p>Street Address _____ Apt. _____</p> <p>City _____ State _____ ZIP _____ County _____</p> <p>Country (if not U.S.) _____ Address Effective Date _____</p> <p>Permanent Phone _____ Cell Phone _____</p>
<p>MAILING ADDRESS</p> <p><i>This is your local address and the address where you would like mail from NYMC sent, only include if different from your Permanent Address.</i></p>	<p>Street Address _____ Apt. _____</p> <p>City _____ State _____ ZIP _____ County _____</p> <p>Country (if not U.S.) _____ Address Effective Date _____</p> <p>Phone _____ Cell Phone _____</p>
<p>BUSINESS ADDRESS</p> <p><i>This is your employment address. Generally, this information is used to contact you in the event of a class cancellation or contact during non-class daytime hours. It can be inactivated by the Office of the Registrar at your request.</i></p>	<p>Name of Employer _____</p> <p>Address _____</p> <p>City _____ State _____ ZIP _____ Bus Phone _____</p>

Student Signature _____ Date _____

For Office Use: Processed (date) _____	Initials _____	Department: _____
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