

UNIVERSITY OF KENTUCKY COLLEGE OF MEDICINE
FALL 2009 ELECTIVE REGISTRATION

PLEASE COMPLETE **ALL** FIELDS

STUDENT NAME: _____

E-mail: _____

First Year

Second Year

MAIL BOX #: _____ PHONE #: _____

NAME OF ELECTIVE: _____

COURSE #: _____ CREDIT HOURS: _____

COURSE INSTRUCTOR: _____

APPROVED BY: _____ DATE: _____

Course Instructor's/Contact's Signature

Please enroll me in the elective above. I understand that I may drop this course at any time by notifying both the instructor and the registrar.

Student's signature

DATE: _____

**Return this form to Student Affairs, 138 Leader Ave.,
by Friday, 5:00 PM, October 2, 2009.**