MEDICINE HAT COLLEGE

Year Long Registration Form

Please Print Clearly

Year _____	Campus ☐ Medicine Hat ☐ Brooks	MHC Student ID # _____

PERSONAL INFORMATION

Last Name	First Name	Middle Name
Previous Name		Phone Number

CURRENT MAILING ADDRESS

Street or Box Number	
City or Town	
Province	Postal Code

CITIZENSHIP

☐ Canadian Citizen ☐ Permanent Resident ☐ Visa Student

Funded by: ☐ Student Loan ☐ Grant ☐ Part-time Bursary ☐ Scholarship ☐ Sponsored _____

PROGRAM OF STUDY

Program Name _____ Program Major _____

☐ Certificate ☐ Diploma ☐ Applied Degree ☐ University Transfer

Year of Program ☐ First Year ☐ Second Year ☐ Third Year ☐ Fourth Year

COURSE SELECTION

SEMESTER	COURSE NAME & NUMBER	LECTURE	LAB	TUTORIAL	PRACTICUM	COMMENTS

*I certify that the above information is correct to the best of my knowledge. The personal information requested on this form is collected under the authority of the Post-secondary Learning Act and Section 33(c) of the Alberta Freedom of Information and Protection of Privacy Act and will be protected under Part 2 of that Act. The information collected will only be used for the purposes of delivery and administration of educational training and services. Questions concerning the collection, use or disposal of this information should be directed to the FOIP Coordinator, Medicine Hat College, 299 College Drive SE, Medicine Hat, AB, T1A 3Y^, or 403-529-3800 or foip@mhc.ab.**ca***

Student Signature: _____ Date: _____

Advisor Signature _____ Date: _____

FOR OFFICE USE ONLY

Total Fees _____ Deposit _____ Balance Due _____ Keyed by _____ Date _____