



University of Health Sciences Antigua Clinical Student Registration Form

- Full Name: _____
First
Middle
Last
- Registration Date: (Month/Day/Year) _____ / _____ / _____ E-mail Address: _____
- Mailing Address: _____
Telephone: _____
- Permanent Address: _____
Telephone: _____
- Citizenship: _____ Sex: Male | Female
- Date of Birth: (Month/Day/Year) _____ / _____ / _____ Marital Status: Single | Married | Widowed | Divorced

Clinical Subject Name	Hospital Name	Duration Date (Month/Day/Year)	Instructor
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The University assumes no liability for failure to provide educational or related services arising out of or due to causes beyond the reasonable control of the University. The University will, however, exert reasonable effort to provide comparable or substantially equivalent services, but its inability to do so shall not subject it to liability. The University accepts the student registration as an indication that the undersigned will definitely attend, abide with the rules and regulations of the University. Possession of illegal drugs except prescribed medications will result in immediately dismissal from the University.

Advisor's Signature: _____ **Student Signature:** _____

Tuition & Fees Paid: _____ **Received by:** _____