



Audit Registration Form

Registrar's Office
 1435 N. Glenstone Ave.
 Springfield, MO 65802
 Phone (417) 268-1025, Fax (417) 268-1030
records@agts.edu

Date _____ Semester _____ New Student Returning Student

Full Name (Please Print) _____
first *middle* *last*

Address _____

Student ID No. _____

Course Letters	Course Number	Sect	Course Title	Course Credit Hours	Instructor
				Total Hours	

Required Signatures *(It is the responsibility of the student to obtain advisor's signature.)*

Student signature _____

Academic Advisor's signature _____

Registrar's signature _____

Note: This must be submitted by the add/drop deadline to be effective for the current semester.

For Registrar Office Use: Processed by _____ Date _____
