



REQUEST FOR A CHANGE OF SCHEDULE

INDICATE SESSION FOR WHICH CHANGE IS BEING MADE:

___ SPRING ___ SUMMER ___ FALL ___ WINTER _____ YEAR

STUDENT ID (AU ID or SSN): _____

Name: _____

Phone number where you may be reached during the day: _____

Please check if you are receiving:

VA BENEFITS: _____ FINANCIAL AID: _____

I request to **DROP** the following course(s): Dept./Course #/Section #/Course Name.
There is a \$10 fee for each course dropped. This charge will be added to your account.

- 1. _____
- 2. _____

Are you withdrawing from all the courses in which you are enrolled? ___ Yes ___ No

I request to **ADD** the following course(s): Dept./Course #/Section #/Course Name.

- 1. _____
- 2. _____

I accept the academic and financial responsibility for the requested change(s). I understand I will receive a confirmation of these changes after they have been processed.

Student's Signature _____ Date: _____

DELIVER, MAIL, OR FAX THIS FORM TO THE UNIVERSITY.

Mailing Address: Amberton University
1700 Eastgate Drive
Garland, TX 75041-5595

FAX Number: 972/279-9773

IF YOU ARE RECEIVING A REFUND, FILL OUT THE FOLLOWING INFORMATION:

- ___ PLEASE CREDIT MY CREDIT CARD ACCOUNT
- ___ PLEASE HOLD THE CHECK, I WILL PICK IT UP
- ___ PLEASE MAIL THE CHECK TO:

ADDRESS _____

CITY/ST/ZIP _____