LEWISTOWN HOSPITAL SCHOOL OF NURSING
COURSE REGISTRATION FORM

Name_____DOB _____ Date_____

Semester Course(s) Requested:_____

Course Number	Course Name
1. _____	_____
2. _____	_____
3. _____	_____

Student Signature_____ Date_____

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1. Approved Disapproved
2. Approved Disapproved
3. Approved Disapproved

Comments_____

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Faculty Signature_____ Date_____

Faculty Signature_____ Date_____

Faculty Signature_____ Date_____