ROXBURY COMMUNITY COLLEGE
Non-Credit Registration Form

Semester: ______________________

(Please mail-in this form with your payment to Roxbury Community College's DCE.

Last Name ________________________ First Name ______________________

SSN __________ _______ _________ Date of Birth ___________________________

Address____

City _____________________________ State _______ Zip Code __________________

Home Phone _______________________ E-mail _______________________________

Gender (optional): Male ____ Female ____ RCC Student ? Y ___ N ___;

RCC Graduate? Y____ No ____

Example:

Course #	Section	Course Name	Day	Begin Time	End Time	Room	Tuition
CSA 083	*Z1*	*Medical Billing*	*M/W*	*5:30 pm*	*8:30 pm*	*3-106*	*$380.00*

Registration Fee *$10.00*

Total amount to be paid ______

I hereby register in the above course(s) and assume full responsibility for the accuracy of the information provided on this form.

____ ____________
Mater Card/Visa Card Number Expiration Date

____ ____________
Student's Signature Date

____ ____________
Processed by Date

A copy of this registration form can be downloaded and printed out from our website: rcc.mass.edu/DCE