CASE WESTERN RESERVE UNIVERSITY

COURSE SELECTION FORM

Last Name: _____ **First Name:** _____ **ID#:** _____

Term:	**School:** (circle one)		
Fall 20___ Spring 20___ Summer 20___	Undergraduate	Graduate	Other: _____

Have a new address? Have a change in your anticipated graduation date? Send it via e-mail to:
registrar@po.cwru.edu

CRN	SUBJECT		Audit (if applicable)	Pass/Fail* (if applicable)	CR HRS	DAYS	TIME	INSTRUCTOR
E1021	*ECON*	*102*			*3.0*	*M T W R F S*	*8:30 - 9:30 am*	*Smith, R*
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I agree to pay all tuition charges and other fees associated with my registration. I understand that I will be automatically billed for the CWRU Medical Plan during the fall and spring semesters unless I complete a waiver form within 30 days of the first day of class. I may obtain this form from the University Health Service.

ADVISOR SIGNATURE or PIN _____ DATE _____ DEAN'S SIGNATURE _____ DATE _____

STUDENT SIGNATURE _____ DATE _____ ☐ Check if non-degree
Non-degree students must have dean's signature

**UNDERGRADUATE STUDENTS MUST APPLY FOR Pass/NoPass OPTION IN DEAN'S OFFICE DURING THE LAST WEEK OF CLASSES*