ASHLAND THEOLOGICAL SEMINARY
A GRADUATE DIVISION OF ASHLAND UNIVERSITY

ASHLAND THEOLOGICAL SEMINARY
ALUMNI AUDIT REGISTRATION

_____
Date Submitted

Name: _____ _____
Last First Middle Student ID or last 4 digits of SS#

If Married,
Spouse's Name: _____ Telephone: ( ) _____
Home

Email address: _____@_____ Telephone: ( ) _____
Work or Cell (circle one)

Address: _____
Street City State Zip Code

☐Please indicate if any of the above information is new.

☐Fall 20____ ☐Spring 20____ ☐Summer 20____
(Please select only one)

ATS Degree: _____ **Graduated from ATS:** _____/_____
mm yy

_____

Current Employer:

_____

Subjects of Interest for continuing education, workshops or lecture series:

_____

Do you receive invitations to Ashland events? ☐Yes ☐No

REGULARLY SCHEDULED CLASSES:

	Subject	Course Number	Section	Course Title	Campus
First Choice					
Second Choice					

Please email this form to: ATS-Registrar@ashland.edu, or mail to:
Ashland Theological Seminary
910 Center Street
Ashland OH 44805
Attn: ATS Registrar

Student's Signature: _____

FOR OFFICE USE ONLY:

Faculty Approval: _____ Date Received: _____

Administrative Approval: _____ Date Registered: _____