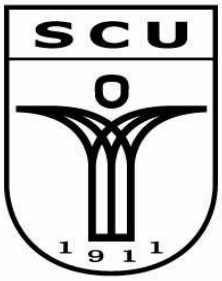
Southern California University
of Health Sciences



Change of Address Form

Please Print

New Address:

Student #: _____ Birthdate: _____

Effective Date: _____ Last four digits of S.S. #: _____

Name: _____
Last First Middle Initial

Address: _____

_____
City State Zip Code

Phone #: (_____) _____ - _____

Signature: _____

Please fax to: (562) 902-3306

For Use by Office of the Registrar:

Copies to: _____ Business Office _____ Library _____ Student Clinic

Date Distributed: _____ Rev 9/07 JMH