Concurrent Enrollment Agreement

Chadron State College

Return Form to: CSC START Office
1000 Main Street, Chadron NE 69337
Fax to: (308) 432-6474

Name _____ Student's Identification (ID) Number _____

Period of enrollment: _____Fall 20___ _____ Spring 20___ _____ Summer 20___

CSC degree: _____ Bachelor of Arts _____ Bachelor of Science in Education
_____ Bachelor of Science _____ Bachelor of Applied Science

Regional West Medical Center	Course(s):	Course #	Credit Hours	Course Name
	_____	_____	_____	
	_____	_____	_____	
	_____	_____	_____	
	_____	_____	_____	

By signing below, I understand the following.

- The classes above are required for my degree program at CSC
- I am receiving my financial aid from CSC
- I must maintain Satisfactory Academic Progress in accordance to CSC Financial Aid policy
- Following the completion of my Regional West Medical Center course(s), I will provide an official Regional West Medical Center transcript to CSC Record's Office. Failure to do so may result in a financial aid suspension.
- I give my permission to Regional West Medical Center to release my final grades for the course(s) listed above to the CSC Financial Aid Office so that my Satisfactory Academic Progress may be measured at the end of this enrollment.
- My financial aid award will be based on my enrollment status according to CSC enrollment policies
- My financial aid will be disbursed directly to my student account at CSC
- I am responsible for paying my tuition and fees at Regional West Medical Center

Student Signature _____ Date_____

To be completed by the Regional West Medical Center, 4021 Ave B, Scottsbluff NE, 69361

Tuition/fees $_____ Room/board $_____ Books/supplies $ _____

Enrollment period: Begin date: _____ End Date: _____

I certify the above student is registered for _____Regional West Medical Center credit hours for this enrollment period. I also certify Regional West Medical Center will not award financial aid for this enrollment period. Regional West Medical Center will notify the CSC Financial Aid Office of any changes in enrollment status for the above student.

_____ _____
Signature of Regional West Medical Center Financial Aid Official — Date

To be completed by CSC RECORDS Office:

I certify the above student is enrolled at CSC and is considered degree seeking. I also verify _____ Regional West Medical Center credit hours for this enrollment period are required for the current degree program or are part of CSC academic requirements for enrollment at CSC.

_____ _____
Signature of CSC Record's Office Official — Date

To be completed by CSC Financial Aid Office:

Fulltime ___ ¾ time ___ ½ time___ <1/2 time___

_____ _____
Signature of CSC START Financial Aid Official — Date