



STUDENT INFORMATION	
Name: _____	Pounce ID #: _____
Current Address: _____	
City _____	State _____ Zip Code _____
Telephone #: (____) _____ - _____	E-Mail: _____@augusta.edu
AU PhD date of matriculation: semester _____ year _____	

**\*\*\* It is understood by the undersigned individuals that funding for this student's Graduate Research Assistantship Stipend and individual Student Health Insurance Premium will be the responsibility of the Major Advisor, Graduate Program, and Advisor's department beginning the students 5<sup>th</sup> semester of enrollment**

Program Choice: \_\_\_\_\_

Lab Room #: \_\_\_\_\_ Lab Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Program Department Funding: Start date Jan 1, \_\_\_\_\_

Authorized Signatures		
_____ Major Advisor	_____ Signature	_____ Date
_____ Department Chair <i>(or Associate Dean for Academic Affairs in Nursing)</i>	_____ Signature	_____ Date
_____ Graduate Program Director	_____ Signature	_____ Date
_____ MD/PhD Director <i>(required for MD/PhD students)</i>	_____ Signature	_____ Date
_____ Dean, The Graduate School	_____ Signature	_____ Date

**\*\*Please return this form to [TGSenrolled@augusta.edu](mailto:TGSenrolled@augusta.edu) \*\***

**This form will be submitted to the Office of the Registrar via TGS.**

**The registrar's office will distribute confirmation to: Office of Academic Admissions, Cashier, Financial Aid, Mailroom Services, Computer Services, Housing Office, & Student Loan Office.**