ASHLAND THEOLOGICAL SEMINARY REGISTRATION

Please print legibly.

ASHLAND THEOLOGICAL SEMINARY
A GRADUATE DIVISION OF ASHLAND UNIVERSITY

Please submit this form to:

OFFICE OF THE REGISTRAR
Ashland Theological Seminary
910 Center Street
Ashland OH 44805

PH 419.289.5907
FX 419.289.5650
ATS-Registrar@ashland.edu

Name (Last, First, Middle) _____

If Married, Spouse's Name _____ Home Phone _____

Student ID # _____ Cell Phone _____

ATS Email _____ Work Phone _____

Street Address _____

City _____ State _____ Zip Code _____

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

TERM
(one term per form)

☐ Fall
☐ Spring
☐ Summer 20____

DEGREE PROGRAM

**If changing degree program, you must contact the Registrar's Office.*

☐ M.A. in _____
☐ M.A. (Biblical/Historical/Theological Studies)
☐ M.A. in Counseling
☐ M.A. in Clinical Mental Health Counseling
☐ Master of Divinity
☐ Master of Divinity (Chaplaincy)
☐ Pre-Doctor of Ministry

Guest Student: ☐ Audit ☐ Credit

PERSONAL DATA

Citizenship:
☐ USA
☐ Other (Specify)
_____
_____

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino

Race:
☐ American/Alaskan Native
☐ Asian
☐ Black or African American
☐ Hawaiian/Pacific Islander
☐ White

Birthdate (mm/dd/yy):
_____

Sex:
☐ Male
☐ Female

Marital Status:
☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Separated

FINANCIAL INFORMATION

Spouse Rate:
☐ Yes
☐ No

VA Benefits:
☐ Yes
☐ No

Scholarship:
☐ Church
☐ Seminary
☐ Other

Student Loan:
☐ Yes
☐ No

Anticipated Graduation Date:
(month/year) _____

Name (Last,First) _____ Denomination (Be Specific) _____

REGULARLY SCHEDULED CLASSES

Specify where you will attend each class:

SUBJECT	COURSE NUMBER	SECTION	CREDIT HRS	COURSE TITLE	CAMPUS

DIRECTED/INDEPENDENT STUDIES (MUST BE APPROVED)

SUBJECT	COURSE NUMBER	CR.	COURSE TITLE

Total Hours _____ Student's Signature _____ Date Submitted _____