



UNIVERSITY OF PIKEVILLE

KENTUCKY COLLEGE OF OPTOMETRY

PERMISSION FOR COURSE AUDIT

Date: _____

Semester/Term: _____ Year: _____

Student Name: _____ Student ID #: _____

I wish to audit the following course(s):

Course Title & number	Credits	Day/Time	Instructor's signature

Auditors pay no tuition or fees. With audited classes, no credit is granted and a designation of "AU" will be assigned on the transcript.

Student's Signature _____ Date: _____

Director of Student Affairs: _____ Date: _____

Associate Dean of Academic Affairs: _____ Date: _____

Office of Student Financial Services: _____ Date: _____

Registrar: _____ Date: _____