Consortium Agreement

Student Name _____ AMSC ID# _____

E-mail Address _____ Phone # _____

Consortium Semester: ◯ Fall ◯ Spring ◯ Summer Academic Year _____

Do you plan to register at AMSC during the consortium semester? (Select one) ◯ Yes ◯ No

If yes, how many hours do you plan to take at ASMC? _____

Name of Host Institution_____ Contact Person _____

Contact E-mail _____Contact Phone # _____

All information provided on the Consortium Agreement is correct to the best of my Knowledge.

Student Signature _____ Date ____/_____/_____

Program Cost of Attendance:

Tuition and Fees: $_____
Room and Board: $_____
Transportation: $_____
Miscellaneous: $_____
Total: $_____

First day of class (es) ____/_____/_____

Last day to drop/add class (es) _____/_____/_____

Enrollment Status: ◯ Semester ◯ Quarter

Total number of hours enrolled _____

As a representative of the host institution you agree to:

- Confirm the student is in a transient/visiting status at your school taking courses that meet the Title IV, and State financial aid requirements.
- Not award any federal, state (excluding HOPE) institutional or private aid during the time the student is enrolled at your school.
- **Notify AMSC if the student fails to register, reduces the number of credit hours or withdraws from classes.**

_____ _____

Host Institution Representative Signature Date

_____ _____

Print Name E-mail Address

_____ _____

Phone # Fax #

Complete form can be return to:
Atlanta Metropolitan State College,
Office of Student Financial Aid
1630 Metropolitan Pkwy Atlanta, Georgia 30310
Or fax to: (404)-756-4927