

# Western Oregon University

## Audit Authorization



Name: \_\_\_\_\_ ID: \_\_\_\_\_

Fall  Winter  Spring  Summer Year : \_\_\_\_\_

CRN: \_\_\_\_\_ Course Subject and Number: \_\_\_\_\_

Instructor's Name: \_\_\_\_\_

Instructor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this form, I acknowledge that I am financially responsible for the tuition and fees associated with the above course. I acknowledge that it is my responsibility to be aware of deadlines for adding/dropping/withdrawing from courses.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Directions:** Complete this form and email a pdf copy or picture to [registrar@mail.wou.edu](mailto:registrar@mail.wou.edu) from your WOU email address. The Office of the Registrar can accept instructor emails in lieu of instructor signatures. Forward or attach the instructor emails when you submit your document. Reach out to the Office of the Registrar if you have questions or require assistance at (503)838-8327.