

VERIFICATION REQUEST

Name _____

Student ID or S.S.# _____

Student Phone _____

(Optional) Anticipated Graduation Date _____

*Pick-up on A Later Date _____

Mail To the Following Address:

Attn: _____

[Please Indicate the Term(s)]

Fall _____ Year

Spring _____ Year

Summer _____ Year

FAX To the Following Number:

(Optional) Insurance Purposes:

Policy Holder _____

Policy Number _____

Attn: _____

STUDENT SIGNATURE _____

***PLEASE NOTE: THERE IS A 24-HOUR TURN-A-ROUND TIME TO PROCESS VERIFICATIONS. AFTER TWO WEEKS, ALL HELD VERIFICATIONS WILL BE MAILED.**

ENROLLMENT SERVICES USE:

RECEIVED BY _____ DATE _____

PROCESSED BY _____ DATE _____