SCHOOL OF HEALTH RELATED PROFESSIONS

University of Medicine & Dentistry of New Jersey

Office of Enrollment Services

ENROLLMENT/GRADUATION VERIFICATION REQUEST FORM

Please PRINT Legibly. When complete, please fax, mail or hand-deliver (see fax # and mailing address below) to Enrollment Services:

First Name ___________________________ Middle Name: _______________ Last Name: _________________________________

Student ID#___________________________ Program/Major: _______________________ If Joint Program, Affiliate:____________

Daytime/Cell Phone #: _(___)__________ Home Phone #: _(____)___________ Email Address:_____________________

Please mail to this Address: OR Please fax: ___________________________

Send to the attention of:

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Reason for Verification Request:

Confirmation of Degree Awarded with Grad Date
Requirements for Graduation Completed
Employment/Human Resources
Expected Graduation Date of ______________
G.I. Bill
Insurance Purposes
Status Confirmation (i.e. PT, FT) for _________
Schedule of Courses per Term
Tuition Reimbursement
VA-Vocational Rehabilitation Program
Other: ____________________________

Student would like to pick-up at Enrollment Services Center on _______________________

Indicate Range of Enrollment Verification:

Individual Academic Term: (ex: Fall 2005): ___________________________________

Multiple Terms: (ex: Fall 2005) _____________ to (ex: Spring 2006) _____________

Special Requests:

I, _________________________ understand that I will be releasing confidential information that may contain my academic standing, birth date, degree status, course registration, address and social security number to a third-party or individual.

Student Signature: _______________________________ Date of Submission: ___________

ENROLLMENT SERVICES USE ONLY

Enrollment Services signature___________________________________ Date processed in Banner___________

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