REQUEST FOR VERIFICATION OF ENROLLMENT

STUDENT NAME _____Date_____
(Please Print) First Middle Last

_____ _____/_____
Signature MC ID (Enrolled Fall 2007 or later) or SSN (prior to Fall 2007)

LOCAL ADDRESS _____ _____
Street or Box Number City, State, Zip Code

Local Phone or Cell Number _____ Anticipated Date of Graduation _____

VERIFICATION OF ENROLLMENT FOR_____ SEMESTER

PLEASE MAIL TO:_____ FAX TO:_____
(Fax #) ($10.00 Fax Fee)

_____

_____

If for insurance purposes: INSURANCE INFORMATION

NAME OF POLICY HOLDER _____ADDRESS_____

POLICY HOLDER #_____ GROUP #_____

FOR OFFICE OF THE REGISTRAR USE ONLY

ENROLLMENT:	SEMESTER	BEGIN DATE	END DATE	HOURS	FT OR HT

The information included herein is correct.

_____ _____
Enrollment Verification Clerk Date
Office of the Registrar

5/13