UNIVERSITY OF CENTRAL FLORIDA
College of Medicine

ENROLLMENT VERIFICATION
OR
GOOD STANDING REQUEST

ACADEMIC YEAR OR YEARS (to be verified): _____

Today's Date: _____

CLASS OF: _____

STUDENT NAME: _____

Student's Signature to Authorize Release Information

_____

ADDRESS INFORMATION
(Send Verification or Letter to)

Attention: _____

Address or P.O. Box: _____

City: _____ State: _____ Zip: _____

Fax: _____

Or Student's Mailbox (Box #) _____

Reason for Request

Insurance Company _____ Away Rotation Letter _____
Credit Card Company _____
Scholarship _____
Miscellaneous _____