ENROLLMENT DOCUMENTATION REQUEST FORM

University of Central Florida
College *of* Medicine

PERSONAL INFORMATION

Please type or print all sections below legibly (*All contact information below is required)*

Name (First, Middle/Maiden, Last): _____

UCF ID: _____ **Academic Year(s) To Be Verified:** _____

Today's Date: _____ **Date Needed By**: _____

DOCUMENT(S) REQUESTED: *Transcripts and Immunization Records must be requested through separate forms*

□ Enrollment Verification □ Proof of Liability Insurance □ Photo □ Other: _____

□ Letter of Good Standing *(letter includes enrollment verification, academic status, and certifications)*

INSTITUTION INFORMATION *(Contact Information for the Third Party Receiving the Documents Must Be Provided)*

The Registrar's Office is not responsible for a provided incorrect address. If it is incorrect and cannot be delivered, you will have to request another document with the correct address. *(List additional addresses on separate sheet if necessary.)*

Reason for the Request: _____

Institution/Company Name: _____

Contact Name (First, Last): _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

METHOD OF DELIVERY *(please select one of the options below)***:**

□ **I will pick up my documents in COM Student Affairs** □ **Fax:** _____

□ **Mail to the address listed above**

□ **Email:** _____

SIGNATURE

Student Signature _____ **Date** _____

PLEASE ALLOW AT LEAST THREE (3) BUSINESS DAYS TO PROCESS.

Be sure to sign above. UNSIGNED OR INCOMPLETE FORMS CANNOT BE PROCESSED!

Return completed form to:

College of Medicine Registrar's Office
6850 Lake Nona Blvd., Suite 115,
Orlando, FL 32816-0114
407.266.1373 | comregistrar@ucf.edu