



UNIVERSITY OF CENTRAL FLORIDA
College of Medicine

ENROLLMENT DOCUMENTATION REQUEST FORM

Allow at least 72 hours to process the request.

STUDENT NAME: _____

ACADEMIC YEAR OR YEARS (to be verified): _____

PID: _____

CLASS OF: _____

TODAY'S DATE: _____

DATE NEEDED BY: _____

DOCUMENT(S) REQUESTED: Enrollment Verification (*includes academic standing status*)

Letter of Good Standing (*includes certification requirements*) Photo

Immunization Record Proof of Liability Insurance Other: _____

REASON FOR REQUEST: Away Rotation Application Credit Card or Insurance Company

Summer Program/Fellowship Scholarship Miscellaneous: _____

INSTITUTION INFORMATION (*please provide the following information*)

Institution/Company Name _____

Contact Person Name _____

Address or P.O. Box _____

City, State, and Zip Code _____

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

Mail (*Only Letters of Good Standing or Enrollment Verification will be mailed to 3rd parties*)

Fax: _____ Pick-up (COM Student Affairs Office)
(*Excluding immunization records*)

E-mail: _____
(*Excluding immunization records*)

Student's Signature to Authorize Release of Information (*required*)

Please email form to comregistrar@ucf.edu or return to the COM Student Affairs Office