



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