



**SCHOOL OF  
PUBLIC HEALTH**

University of Medicine & Dentistry of New Jersey

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## ENROLLMENT VERIFICATION REQUEST FORM

**PRINT CLEARLY**

**Name:** \_\_\_\_\_ **Student I.D.:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Dates of Attendance** \_\_\_\_\_

State below the type of information regarding your status that you wish to release, e.g., anticipated date of graduation, full-time or half-time status, etc. Please note grades cannot be sent via this request form. If you wish to release grade information, you must complete a Transcript Request Form.

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Print the complete mailing address of where or to whom you wish this verification sent.

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_