College of Osteopathic Medicine

Office of the Registrar

ENROLLMENT VERIFICATION FORM

NAME: ________________________________ **E-MAIL**__________________

STUDENT ID #: ___________________ **PHONE :(___) ____-________**

CLASS YEAR: ___________ **CELL: (___) _____-_________**

Information to be verified: Please attach all applicable forms

☐ Enrollment status ☐ Anticipated Graduation Date ☐ Degree Program
☐ Other

____

____

Purpose of Release:

____

____

____

Verifications must be sent directly to the person, agency or school. Include the full name and address

Send to:

____

____

____

I hereby authorize the Registrar's office to release all information above and/or on the attached form(s).

Student Signature________________________________ **Date**_____

NYITCOM at Arkansas State University
P. O. Box 119
State University, AR 72467
Phone: 870-972-2786
Fax: 870-680-8800
comjbregistrar@nyit.edu

NYIT College of Osteopathic Medicine
Northern Blvd., PO Box 8000
Serota Building-Rm 222
Old Westbury, NY 11568-8000
Phone: 516-686-3932
Fax: 516-686-3891
medicineregistrar@nyit.edu