Idaho College of Osteopathic Medicine

STUDENT REQUEST FOR VERIFICATION

Last Name	First Name	Middle Initial	Student ID Number

Verification Type: ☐ Acceptance Verification ☐ Enrollment Verification ☐ Letter of Good Standing ☐ Degree Verification ☐ Class Rank

In what format do you need your verification? ☐ Please draft a letter ☐ I have a form that needs to completed. (Please include your form with this request)

Please provide any specific information that needs to be included in your verification letter or form (if applicable):

_____

_____

_____

I request that my verification be sent by:

☐ **Mail:**

_____
Attention/Recipient

_____
Company/Organization

_____
Street Address

_____
City State Zip Code Country

☐ **Email:**

_____
Recipient

_____
Email Address

Student signature: _____ **Date of request:** _____

By typing my name above, it serves as an official signature to release my educational information.

Note to students: Please allow up to 2 business days for your verification documents to be processed and sent out.

To submit, please save this document and attach it in an email to: aahmadian@idahocom.org

For Office Use Only:

Date request received:_____ Date verification sent: _____

Signature of Registrar: _____