Verification Request Form

Please Print Clearly

Check one: ☐ enrollment ☐ graduation

Name: ____________________________________________

Address: _________________________________________

City: _______________ State: ___________ Zip: __________

Day Phone: _______________________

Anticipated/Actual Graduation Date: ______________________

____________________________________________________

Check if verification will be picked up ☐

If you choose to have the verification mailed, please complete the following information:

Name: ____________________________________________

Address 1: _________________________________________

Address 2: _________________________________________

City: _______________ State: ___________ Zip: __________

Fax: _______________________

Signature: ____________________________ Date: ____________

Please mail or fax completed form to:
Office of Student Academic Services
Kent State University College of Podiatric Medicine
6000 Rockside Woods Blvd. • Independence • OH • 44131
Fax: (216) 447-0626