



STUDENT CHANGE OF ADDRESS FORM

Student Name: _____

UNIVERSITY ID: _____

Class Year: _____

New Address: _____

New Home Telephone #: _____

Cell Phone #: _____

Effective Date: _____

Student Signature

Date

PLEASE NOTE: THIS CHANGE IS FOR THE REGISTRAR'S OFFICE ONLY

**PLEASE RETURN TO: OFFICE OF THE REGISTRAR
ONE MEDICAL CENTER DRIVE
SUITE 210
STRATFORD, NJ 08084
PHONE – 856-566-7055
FAX – 856-566-6475**

CONTACT FINANCIAL AID OFFICE FOR ADDRESS CHANGE