UMDNJ SCHOOL OF OSTEOPATHIC MEDICINE
University of Medicine & Dentistry of New Jersey

REQUEST FOR VERIFICATION OR RECORDS FORM

DATE: _____

TO: Office of the Registrar
UMDNJ-School of Osteopathic Medicine
One Medical Center Drive, Suite 210
Stratford, NJ 08084

REQUESTED BY: _____
(Please Print)

_____
Signature

UNIVERSITY ID: _____ or SSN: _____

CLASS YEAR: _____ TELEPHONE #: _____

Check appropriate box(es) ☐ Verification of Enrollment ☐ Academic Standing
☐ Dates of Enrollment ☐ Anticipated Grad Date

Reason for Verfication:_____
_____

Address To: _____

_____

_____

_____

REQUEST FOR RECORDS: (Please provide a **STUDENT COPY**)

☐ Clinical Evaluation Forms (Please identify)
_____
_____

Score Report: NBOME ☐ Part I ☐ Part II COMLEX ☐ Level 1 ☐ Level 2

☐ Other
_____
_____

DELIVER: ☐ US Mail ☐ Student Mailbox ☐ Pick-Up ☐ Fax _____
(Fax Number)

PLEASE ALLOW TEN DAYS FOR PROCESSING