MEDICAL COLLEGE OF WISCONSIN

ENROLLMENT VERIFICATION

A current student may request enrollment verification by completing this form. The letter of verification will include the student's name, anticipated date of graduation, and a statement the student is enrolled at the Medical College of Wisconsin. A student may submit forms for inclusion with the letter.

Name: _____
(Last name while enrolled at MCW) (First name) (Middle name)

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ E-mail address: _____

Program of Study: _____

I hereby authorize the Medical College of Wisconsin to disclose my name, anticipated graduation date, and enrollment status (e.g. full-time). This information is to be released for the following purpose _____ to:

_____
(First and last name(s) of individual(s) to whom information is to be released and/or institution/organization.)

Please choose one of the options below:

_____ The letter is to be claimed by the student in the Office of the Registrar, M3215

_____ The letter is to be emailed to: _____

_____ The letter is to be mailed to: _____

_____

_____

Signature: _____ Date: _____

*Return this **signed** form to*:
Medical College of Wisconsin
Office of the Registrar, M3125
8701 Watertown Plank Road
Milwaukee, Wisconsin 53226
(414) 955-8733

or

*Return this form by emailing a PDF of the **signed** form to* acadreg@mcw.edu.