NEW YORK INSTITUTE OF TECHNOLOGY
College of Osteopathic Medicine

Office of the Registrar

ENROLLMENT VERIFICATION FORM

NAME: _____ E-MAIL_____

STUDENT ID #: _____ PHONE :(___) ____-_____

CLASS YEAR: _____ CELL: (___) _____-_____

Information to be verified: Please attach all applicable forms

□ Enrollment status □ Anticipated Graduation Date □ Degree Program
□ Other

_____

_____

Purpose of Release:

_____

_____

_____

Verifications must be sent directly to the person, agency or school. Include the full name and address

Send to:

_____

_____

_____

I hereby authorize the Registrar's office to release all information above and/or on the attached form(s).

Student Signature_____ Date_____

NYITCOM at Arkansas State University
P. O. Box 119
State University, AR 72467
Phone: 870-680-8808
comjbregistrar@nyit.edu

NYIT College of Osteopathic Medicine
Northern Blvd., PO Box 8000
Serota Building-Rm 222
Old Westbury, NY 11568
Phone: 516-686-3852
medicineregistrar@nyit.edu