LIBERTY UNIVERSITY | COLLEGE of OSTEOPATHIC MEDICINE

Office of the Registrar

Enrollment Verification Letter Request

Student Information (Please Print)

Name: _____ Liberty Student ID: _____

Previous Name: _____ Date of Birth (mm/dd/yy):____/____/____

Email: _____ Phone Number: (_____) _____-_____

Request Information (Please Print)

Delivery Options:

☐ Pickup

☐ Send to the below address:

Attn:_____

Address:_____

_____

_____

☐ Fax:_____

☐ Email: _____

Quantity Requested:_____

Semester: ☐Fall ☐Spring ☐Summer

Year:_____

Special Instructions & Purpose:

☐ Attach form included with request

☐ Other:_____

_____

Purpose:

☐ Insurance ☐ Deferment

☐ DMV ☐ Other:_____

Verification of:

☐ Enrollment Status (Full Time/Part Time)

☐ Degree Conferral

☐ Standing

Authorization (Please Print & Sign)

Student's Signature:_____ **Date:**_____

**By signing this form you authorize the LUCOM Registrar's Office to send your enrollment verification(s) to the designated person or organization listed above.*

Contact Information & Instructions

Submit Request(s) to:

College of Osteopathic Medicine
Registrar's Office
306 Liberty View Lane, Lynchburg, VA 24502
Tel. (434) 592-5200 · Fax (434)582-3902 · lucomregistrar@liberty.edu

*Allow 3-5 business days for processing.

Registrar's Use Only *Processed By:*_____ *Date:*_____