

**REQUEST FOR VERIFICATION
OF ENROLLMENT OR
RELEASE OF INFORMATION**



**Registrar's Office
PO Box 1000
Park Hills MO 63601
(573) 518-2119
FAX: (573) 518-2166**

Name _____ SS # or MAC ID# _____

Address _____

Street Address

City

State

Zip

Date of Birth _____ Day Phone # _____ E-mail _____

Semester(s) to be verified ___ Fall ___ Spring ___ Summer Year(s) _____

FOR INSURANCE PURPOSES, if you are under your parent/ guardian's plan, please provide parent name for identification

Parent name _____

.....
Delivery Method (circle one): Mail (include address below) Fax (include number below) Student Pick Up

Send Verification to: _____ Fax Number: _____

Company name or representative

Mailing Address

City

State

Zip

By my signature below, I hereby authorize the release of my verification of number of hours enrolled, G.P.A. or other information

(Student Signature Required)

(Date)

*NOTE: VERIFICATIONS RECEIVED AT THE BEGINNING OF THE SEMESTER WILL BE PROCESSED TWO (2) WEEKS AFTER CLASSES BEGIN