

Enrollment Verification Request Form

Kansas City University of Medicine and Biosciences
 Registrar's Office
 1750 Independence Avenue
 Kansas City, MO 64106
 Phone: 816-283-2332
 Fax: 816-283-2307

Student's Name: _____ S.S. #: _____
 Graduation Year or Last Date of Attendance: _____
 E-mail: _____
 Street: _____ Apt. #: _____
 City: _____ State: _____ Zip: _____
 Phone: _____

Please mark the following for your request:

	Verification Form – Prepared form that you are providing the Registrar's Office
	Verification Letter – Letter composed by the Registrar's Office on Official KCUMB Letterhead.
	Official Transcript
	State Licensing Board
	Credentialing Group

Send to the following address:

Your Signature: _____ Date: _____

Office Use Only:

Date Received:	Date Processed:	Check #:	Check Amt:	Cash Amt:
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Note: This form must be printed and sent to the Registrar's Office with your signature.