GRADUATION DATE VERIFICATION FORM

Applicant's Name:	
School Name:	
School Mailing Address:	
City:	State:
Zip Code:	County:

ATTENTION! If this page is not SIGNED and DATED by the Program Director or an appropriate designee, the application will be considered INCOMPLETE and INELIGIBLE. The person signing this section may not be related to the applicant by blood, marriage, or adoption.

TO BE FILLED OUT BY YOUR PROGRAM DIRECTOR OR AN APPROPRIATE

Program accepted or enrolled:		
Date health professions program started:		
Expected graduation date from program:		
Date graduated from program (to be completed upon graduating):		
Enrollment status (select one):	Full Time	Part-time
Grade Point Average:		
# of units currently enrolled:	Type of units:	
(minimum of 6 units or equivalent modular units)		

Name (please print):	
Title:	Phone/Ext.
Email Address:	

1. I understand that, should the applicant be awarded, I agree to sign certifications to show the student is in good standing and enrolled in the program each semester until said applicant graduates.
2. I declare under penalty of perjury that the information contained in this section is true and correct to the best of my knowledge.

Signature: **Date:**

Applicant: Input this information, exactly as your Program Director or Appropriate Designee has verified, onto the Supporting Documentation Page of your application.