UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

CERTIFICATION/VERIFICATION OF ENROLLMENT REQUEST FORM

(Please print clearly)

Name: _____ **My USA ID#:** _____

Date Enrolled: _____ **Expected Graduation Mo/Year:** _____/_____

Current Trimester of Enrollment: _____ **Program:** _____

Send Letter to: _____

_____

_____

_____

_____ _____

Signature **Date**

(For Office Use)

Date Received: _____

Date Processed: _____ **by**_____

Fax: 904-810-3819
Attn: Registrar's Office

Revised 5/2011