Cleveland University
KANSAS CITY
Chiropractic and Health Sciences

VERIFICATION REQUEST FORM

Name: _____
Last **First** **Middle**

Address: _____

Social Security Number: _____-_____-_____ **or** **Date of Birth:** _____

Phone: _____

Send to: _____ **Number of Copies:**_____

_____

_____

Fax or email to: _____

Unofficial Transcripts ☐

Enrollment letter ☐

Physiotherapy letter ☐

Good Standing letter ☐

Credit Hours letter ☐

Schedule copy ☐

Graduation Verification ☐

Jury Duty Exemption letter ☐

Other ☐

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby authorize Cleveland University-Kansas City to release my verification of academic record to the above indicated institution or individual.

Charge: $___No Charge_____

_____

Signature **Date**