Mississippi College
A CHRISTIAN UNIVERSITY

REQUEST FOR VERIFICATION OF ENROLLMENT

STUDENT NAME(Please Print) _____
First   Middle   Last

_____   _____
Signature   Social Security Number

LOCAL ADDRESS _____   _____
                      Street or Box Number   City, State, Zip Code

Local Phone _____   Date_____

☐ VERIFICATION OF ENROLLMENT FOR_____ SEMESTER

INSURANCE INFORMATION:
NAME OF POLICY HOLDER _____ADDRESS_____

POLICY HOLDER #_____   GROUP #_____

PLEASE MAIL TO:_____   FAX TO:_____

_____

_____

FOR OFFICE OF THE REGISTRAR USE ONLY

ENROLLMENT: <u>SEMESTER</u>   <u>BEGIN DATE</u>   <u>END DATE</u>   <u>HOURS</u>   <u>FT OR HT</u>

SEMESTER	BEGIN DATE	END DATE	HOURS	FT OR HT

The information included herein is correct.

_____   _____
Records Assistant   Date
Office of Registrar