



UConn Health Office of the Registrar
Attn: Transcript Services
263 Farmington Avenue
Farmington, CT 06030-1826
Phone: 860-679-3125 Fax: 860-679-1902
Email: registrar@uchc.edu
Office: Academic Building, AM039

Verification of Enrollment Requests: Medical, Dental, & Current Graduate Students

Student's Name (Last, First, MI): _____

Other name(s) used during attendance: _____

Date of Birth: ____/____/____ School (Medical or Dental): _____

Dates of Attendance: From: _____ To: _____

Please provide preferred contact information where you may be reached:

Phone: _____ Email: _____

I hereby authorize the University of Connecticut to release verification of enrollment and related documents to the recipient named on this form.

Date: ____/____/____ Signature: _____
(Handwritten signature required; we cannot accept a digital or typed signature)

If you have Board of Education, licensing verification, or other agency forms, please include them with this form.

Photo Identification: Requests that require a verification of your current photo must be accompanied by a copy of either: your current Driver's License, a current photo ID, or a notarized copy of your name and photograph. Our office cannot verify the photograph section of the form otherwise.

____ **Prepare an enrollment verification for pickup in the UConn Health Office of the Registrar:**
Please check item(s) requested: USMLE Scores _____ Travel Letter _____

____ **Mail an enrollment verification to the following address; please include:**
Please check item(s) requested: USMLE Scores _____ Travel Letter _____
Recipient Name and Address:

Verification of Residencies or Fellowships should be directed to the respective schools as noted below:
Graduate Medical Education (Residency/ Fellowships) via email to gmeoffice@uchc.edu or via fax to: 860-679-4624
Dental Student Affairs (Residency) via fax to: 860-679-1899