STATE UNIVERSITY OF NEW YORK HEALTH SCIENCE CENTER AT BROOKLYN
OFFICE OF THE REGISTRAR
450 CLARKSON AVENUE BOX 98
BROOKLYN, NEW YORK 11203
TELEPHONE – (718) 270-4551 FAX - (718) 270-7592

REQUEST FORM

(DOCUMENT REQUEST, REQUEST FOR CHANGE OF PERSONAL DATA)

***NOT FOR USE BY STUDENTS IN THE SCHOOL OF GRADUATE STUDIES**

CHECK HERE IF CURRENTLY ENROLLED

NAME: _____ SID _____ BOX #: _____
(SSN FOR ALUMNI STUDENTS)

COLLEGE: MEDICINE CHRP NURSING PH FILL IN GRAD DATE OR LAST DATE OF ATTENDANCE: _____/_____

_____ _____ TELEPHONE: _____
STUDENT SIGNATURE DATE OF REQUEST

I. DOCUMENT REQUEST *(Check all appropriate boxes)*

ENROLLMENT VERIFICATION
GRADUATION CERTIFICATION
HIPAA CERTIFICATE
DEAN'S LETTER
LETTER OF GOOD STANDING (Off-Campus Elective)
OFFICIAL TRANSCRIPT ($5 Transcript Fee)
OFFICIAL TRANSCRIPT FOR VSAS ($5 Transcript Fee)
LICENSURE FORM ($15 Licensure Fee includes official transcript)
STUDENT COPY OF TRANSCRIPT (Free if current student)
OTHER _____

MAIL DOCUMENT TO: CHECK THIS BOX IF YOU WILL PICK UP DOCUMENT FROM REGISTRAR

_____

_____

_____

II. CHANGE OF ADDRESS AND/OR TELEPHONE NUMBER

EFFECTIVE DATE OF CHANGE: _____/_____/_____

LOCAL MAILING ADDRESS LOCAL MAILING TEL NUMBER PERMANENT ADDRESS PERMANENT TEL NUMBER

(ID MUST BE PRESENTED BEFORE CHANGE WILL BE MADE)

NEW ADDRESS: _____
STREET

_____ NEW TELEPHONE: (_____)_____
CITY STATE ZIP CODE AREA CODE NUMBER

III. CHANGE OF NAME OR SOCIAL SECURITY NUMBER

EFFECTIVE DATE OF CHANGE: _____/_____/_____

NEW NAME: _____ NEW SOC SEC NUMBER:_____
LAST FIRST MIDDLE

_____/_____/_____
REASON FOR CHANGE: _____ TODAY'S DATE

12/2010