Sherman College of Chiropractic
REQUEST FOR ENROLLMENT OR DEGREE VERIFICATION

Name: _____
Name, if different during enrollment: _____
Date of Birth: _____
Matriculation (Start) Month/Year : _____
Graduation Date: _____

Please check the verification letter you are requesting:

_____ Enrollment Verification
_____ Expected Graduation Date
_____ Graduation Date
_____ Other: _____

Please check one: _____ I will pick up on ___/___/____
_____ Please email to _____
_____ Please mail to
(full address) _____
_____
_____
_____

Please list any additional information below.

_____
_____
_____
_____

_____ _____
Student/Alumni Signature Date

Return completed/signed form via fax to 864-599-4851
or email to registrar@sherman.edu

(Office Use) Date Sent: _____