REQUEST FOR VERIFICATION OF STUDENT STATUS

NAME: _____ **SIGNATURE:** _____

CLASS: _____ **DATE:** _____

Please send the form checked to the email/address indicated below:

_____ **Certificate of Registration/Enrollment**

_____ **Certificate of Good Standing**

_____ **Certificate of Good Standing for Outside Elective**

_____ **Other:** _____

Email or Address to send to:

_____

_____

_____

_____

Completed request forms should be sent to:
Email: camedreg@bu.edu
I**n Person:** Boston University Chobanian & Avedisian School of Medicine
The Office of the Registrar
72 E. Concord Street, **Room A414**
Boston, MA 02118
Fax: (617) 358-7551