



DEPARTMENT OF VETERANS AFFAIRS  
Boston Healthcare System  
Brockton Campus  
940 Belmont Street  
Brockton, MA 02301

**SUMMER**  
Student Verification Form

**Instructions: Please complete all parts of this form.**

1. Have a School Official sign and date Part I.
2. Student must sign and date Part II.

**PART I**

Today's Date: \_\_\_\_\_

Student Full Name: \_\_\_\_\_

College/University: \_\_\_\_\_ State: \_\_\_\_\_

*Is this student:*

**Currently enrolled at Least Half-time? YES or NO** **Current GPA:** \_\_\_\_\_

**Accepted for enrollment for the upcoming semester at least half-time? YES or NO**

**Number of credits, semester hours, or quarter hours completed to date:** \_\_\_\_\_

**Major:** \_\_\_\_\_ **Expected Graduation Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
**Name and Title of Verifier:**

\_\_\_\_\_  
**Signature:**

**Date:** \_\_\_\_\_

**PART II**

I give permission for the release of the above information to the VA Boston Healthcare System.

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Date**

**Student Email address/Phone #:** \_\_\_\_\_