



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

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.
3. Fax completed form to: Recruitment Office (fax # 774-826-1187)

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 #: _____

PART III

Fax completed form to fax # 774-826-1187, Attn: Recruitment Office.