TOURO COLLEGE OF OSTEOPATHIC MEDICINE
REQUEST FROM THE REGISTRAR

☐ College of Osteopathic Medicine ☐ College of Pharmacy
☐ College of Health Science

Class of _____

Name _____ **Student ID#** _____
(Required)

Address _____
(Number, City, State, Zip Code)

Phone Number _____
(Required)

E-Mail _____

(Please check appropriate request)

☐ Change of Address/Phone/E-mail
☐ Complete attached application
☐ Enrollment Verification Letter
☐ Other (Please indicate below)

(Mail to / personal information change / other request below)

_____ _____
_____ _____
_____ _____

_____
Student Signature (Required) *Date*

REGISTRAR _____ Date Completed _____

Mailed ____ Faxed ____ E-mailed ____ Date Completed _____