



## GRADUATION DATE VERIFICATION FORM

Applicant's Name:	
School Name:	
School Mailing Address:	
City:	State: California
Zip Code:	County:



**ATTENTION!** If this page is not SIGNED and DATED by the Program Director or an appropriate designee, the application will be considered INCOMPLETE and INELIGIBLE. The person signing this section may not be related to the applicant by blood, marriage, or adoption.

<b>TO BE FILLED OUT BY YOUR PROGRAM DIRECTOR OR AN APPROPRIATE</b>
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Program accepted or enrolled:	
Date health professions program started:	
Expected graduation date from program:	
Enrollment status (circle one):	Full Time <span style="margin-left: 100px;">Part-time</span>
Grade Point Average:	
# of units currently enrolled:	Type of units:
(minimum of 6 units or equivalent modular units)	
<b>I verify that the applicant can speak the following language(s) in addition to English:</b>	
Language(s):	
Name (please print):	
Title:	Phone/Ext.
Email Address:	

1. I understand that, should the applicant be awarded, I agree to sign certifications the student is in good standing and enrolled in the program each semester until said applicant graduates.
2. I declare under penalty of perjury that the information contained in this section is true and correct to the best of my knowledge.

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

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

**Applicant: Input this information, exactly as your Program Director has verified, onto the Supporting Documentation Page of your application.**