Request for Academic Credentials Verification

FOR APPLICANT TO COMPLETE BEFORE SUBMITTING TO INSTITUTION

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH (MM/DD/YY)	FILE NUMBER

INSTITUTION/SCHOOL ATTENDED: ____

DATES OF ATTENDANCE (MM/DD/YYYY) FROM: ________________________ TO: ______________________

NAME WHILE ATTENDING (*if different from name above):*

____

LAST FIRST MIDDLE

HOME PHONE: _____________________________________ WORK PHONE: _________________________________

Email: ____

I hereby authorize the release of my educational records to FACTS.

____

APPLICANT SIGNATURE

____

DATE

FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FACTS

Directions for Registrar: Complete this form and send along with the records (transcripts, gradelists, etc. and certificate of clinical internship hours) of the above applicant to:

FACTS
1930 Winter Street
Kingsburg, CA 93631

Name of Institution/University: ____

Name and title of official completing this form: ____

Address of Institution: ____

STREET *CITY*

____

STATE *ZIP CODE* *COUNTRY*

Phone Number: ____

CONTINUED ON NEXT PAGE

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CONTINUED FROM PREVIOUS PAGE

Name of applicant: ____

Name of degree awarded: ____

Credentials required for program admission: ____

Dates of attendance: FROM: __________________________ TO: ________________________

Date of graduation (MM/DD/YYYY): ____

Length of program: ____

SIGNATURE AND SEAL REQUIRED FOR COMPLETION OF THIS FORM

I certify that these responses are complete and accurate to the best of my knowledge. In witness, I hereby set my hand and seal of this institution on this __________________ day of _____________________, 20______________.

Name of official: ____

Official's signature: ____