TOURO COLLEGE OF OSTEOPATHIC MEDICINE
REQUEST FROM THE REGISTRAR

College of Pharmacy

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 _____