



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

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.**

PART I

Today's Date: _____

Student Full Name: _____

College/University: _____

Is this student:

Currently enrolled at Least Half-time? YES or NO

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: _____

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