REGISTRAR'S OFFICE

1537 University blvd.
Morrilton, AR 72110

(501) 977-2052
1-800-264-1094
Fax: (501) 354-7566

registrar@uaccm.edu

CERTIFICATION OF ENROLLMENT REQUEST

Name: ______________________________
(Last Name) (First Name)

Student I.D./S.S. No.: ______________________ **Contact Phone No.:** ______________________

Verify Enrollment for the Following Semester: ☐ Fall ☐ Spring ☐ Summer I ☐ Summer II ☐ Intersession

Request Type: ☐ Loan ☐ Insurance ☐ Other

Initial Next the Requested Method for Which Information is to be Received:

__________ **I will pick this information up at the Registrar's Office on:**__________**after:**__________ .
(Initial) (Date) (Time)

__________ **Please fax this information to:**______________________
(Initial)

__________ **Mail this information to the address listed below:**
(Initial)

(home, institution, or agency)

____
(Street address, P.O. Box, Rural Route, Etc.)

____
(City) (State) (Zip)

Signature: ______________________ **Date:** __________
(Student)

NOTE: Certification Requests are not processed until the registration cycle for the certifying period has closed. At least one working day is required to complete this request.

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