

Marian University
BSRT CLINICAL ENROLLMENT VERIFICATION FORM

In order to verify your enrollment in a clinical program and communicate your academic progress to us, please fill out and send us the following form each semester you are officially enrolled in a clinical program. By indicating your anticipated date of graduation from Marian University, the Registrar's Office can send you graduation application materials in a timely fashion.

Student Name: _____
 Soc. Sec. #: _____
 Mailing Address: _____

 Phone: _____
 Email: _____

Clinical Program Information (to be completed by student):	
Name of Program:	_____
Address:	_____

Phone:	_____

Date of entry into the Clinical Program: ____/____/____

Anticipated Date of Program completion: ____/____/____

Have you completed all your Marian coursework? YES NO (Courses remaining: _____)

Anticipated Date of graduation from Marian University: ____/____/____

- **Please notify the Marian University Registrar's Office in writing if you withdraw from the clinical program before completion.**

I verify that _____ is currently enrolled in our Clinical Radiography Program.	
Student Name	
Program Director _____	Date _____
Signature	

Send to: Registrar's Office, Marian University, 45 South National Ave., Fond du Lac, WI 54935 or FAX to: (920) 926-6708

For questions contact: Dr. John May, Marian University, Fond du Lac, WI 54935 (920) 923-7646 or jmay@marianuniversity.edu