Los Angeles County
COLLEGE OF NURSING AND ALLIED HEALTH
1237 North Mission Road, Los Angeles, California 90033
▸School of Nursing
▸Allied Health Continuing Education
(323) 409-5911
collegeofnursing@dhs.lacounty.gov

REQUEST FOR VERIFICATION OF ENROLLMENT

Please complete this form to request letters verifying you are enrolled in the nursing program. Complete items I-IV as applicable. Letters will be placed in your mailbox unless you indicate otherwise.

I.

Name (PRINT LEGIBLY) _____ Class _____ CON Mailbox # _____

Address _____ e-mail address _____

City _____ State _____ Zip Code _____ Daytime phone # _____

II. Indicate the type of letter you are requesting.

_____ **Standard letter** – verifies enrollment, start/end date of current semester, number of semesters completed and projected graduation date.

_____ **Student nurse worker letter** - meets the requirements for student worker application; verifies enrollment including clinical course, start/end date of current semester, number of semesters completed, and projected graduation date.

_____ **Full-time status letter**– states student is full-time, (College defines full-time as a minimum of 10 semester units), start/end date of current semester, number of units and required class hours.

_____ Other: please specify _____

III. ____ Request to have the attached form completed.

IV. ____ Mail letter to:

Signature _____ Date _____

For office use only:

Date received: _____ Date completed: _____

Date mailed, if requested: _____ Completed by: _____