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 Name:_____

College/University: _____

Is this student **currently enrolled or 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: _____

_____
Name and Title of Verifier:

_____ Date: _____
Signature:

PART II

I give permission for the release of the above information to the VA Boston Healthcare System.

_____ _____
Student Signature Date