

UNIVERSITY OF ILLINOIS
AT CHICAGO
PHONE: (312) 413-7808 FAX: (312) 413-5604

Human Resources
Department of Medicine
College of Medicine
840 South Wood Street (MC 787)
CSB 1031
Chicago, Illinois 60612-7323

Institution Name: _____ Date: _____

Address: _____

City/State/Zip: _____

RE: VERIFICATION OF EDUCATION CREDENTIALS

The person named below has applied for employment with the University of Illinois at Chicago. The applicant states he/she has received a diploma/certification/degree from your institution. Please furnish us with a verification of the information sated below. Please mail this completed form back to:

University of Illinois at Chicago - College of Medicine -Department of Medicine – HR
Attention: Sarah Hopkins - 840 South Wood Street - CSB Suite 1031 – Mail Code 787 - Chicago, Illinois 60612-7323

Applicant Name: _____ Soc. Sec. No: _____

Dates Attended from: _____ to: _____ Name used while attending: _____

Diploma/Certification/Degree Received: _____
Date Received _____

I voluntarily give the University of Illinois at Chicago permission to obtain education verification.

Applicant Signature

DO NOT WRITE BELOW THIS LINE, FOR RESPONDING INSTITUTIONS ONLY.

Is the above information correct? YES NO If not, please indicate any discrepancies.

Dates Attended from _____ to _____

Diploma/Certification/Degree Received: _____

Comments: _____

Institution Representative Signature

Position Title

Date