

SCHOOL OF MEDICAL TECHNOLOGY
Student Status Verification



This is to certify that, with successful completion of the fall / spring semester enrollment,

_____ will have completed the prerequisite courses
Name of student

in the Medical Technology curriculum at _____ and
Name of college/university

will be eligible to enter the clinical (fourth) year at your Medical Technology program. It further certifies that upon notification of successful completion of the clinical training program at your School of Medical Technology, the above-named student will be granted a Bachelor of Science degree in

_____ from _____.
Name of college/university

NOTE: This form may be modified to fit the requirements of the college or university.

Registrar's name: _____

Phone number: _____

Email Address: _____

Registrar's Signature

Date

PLEASE MAIL COMPLETED FORM TO:

Gisele Bauman, Program Director
CoxHealth School of Medical Technology
3801 S. National Ave.
Springfield, Mo. 65807