

LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND

STUDENT VERIFICATION

Member's Name _____

Member's SS# _____ Local Union _____

Student's Name _____

Student's SS# _____

Relationship to Member _____ Date of Birth _____

**BELOW PORTION MUST BE COMPLETED BY THE OFFICE OF THE REGISTRAR OF THE
ACCREDITED SCHOOL, COLLEGE, OR UNIVERSITY ATTENDED.**

(Please type or Print)

This is to certify that _____ is enrolled as a full-time/part-time (circle one)

student. This student will/has received _____ credits for the term/semester which

Begins/began on and ends on _____.

Name of Institution: _____

Address: _____

Telephone Number: _____

Signature of Person Verifying Above Information:

SCHOOL STAMP

(Signature)

Title