SUNY Downstate Medical Center

EDUCATIONAL OPPORTUNITY PROGRAM (EOP) VERIFICATION FORM

FOR GRADUATE PROGRAMS & COLLEGE OF MEDICINE

Applicants must be residents of New York State

Please read SUNY Downstate Medical Center's EOP eligibility criteria before proceeding to fill out this application.

Eligibility

1. Applicants must have been previously enrolled in EOP/SEEK/HEOP/College Discovery.
2. Applicants must submit a signed Verification Form from the institution where they attended as an EOP/SEEK/HEOP/College Discovery student. This completed form must be authenticated (Prior College's stamp/seal) by the applicant's EOP/SEEK/HEOP/College Discovery Coordinator/Supervisor/Verifier.
3. You must apply for financial aid at SUNY Downstate

Student Information (must be a current resident of New York State to retain eligibility)

_____ _____ _____
Last Name *First Name* *Middle Name*

_____ _____ _____
SSN# or student ID *Last Date of Attendance* *Date of Birth*

❑ Male ❑ Female

_____ _____ _____
Telephone (Day) *Telephone (Evening)* *Telephone (Mobile)*

Section 1. To be completed by the Student (Applicant)

I was enrolled in: ❑ EOP ❑ HEOP ❑ SEEK/CD

Previous (most recent) EOP/HEOP/College Discovery/SEEK Institution Information

_____
Name of Institution

_____ _____ _____
City *State* *Zip*

I applied for SUNY Downstate Financial Aid on _____
Date

Section 2. To be completed by prior institution's EOP/SEEK/HEOP/College Discovery Coordinator at your last College/University

_____ _____

Name of EOP/SEEK/HEOP Coordinator/Supervisor/Verifier *Title*

❑ Yes, Student did participate in ❑ EOP ❑ HEOP ❑ SEEK/CD Dates of Enrollment: _____

❑ No, Student did not participate in EOP/SEEK/HEOP

This institution's academic year is based on: ❑ Semesters ❑ Trimesters ❑ Quarters

Year of Admission: Fall_____ Spring _____ Summer _____

In order to be considered for financial aid grant/scholarship, this form must be completed as soon as possible and no later than 30 business days before SUNY Downstate's registration date to:

SUNY Downstate Medical Center
Office of Student Admissions
450 Clarkson Avenue, Box 60
Brooklyn, NY 11203
fax: (718) 270-4775

THIS SECTION IS FOR OFFICE USE ONLY

Date form received by Admissions: _____

Student was accepted to _____ Program on _____ date for entry _____

Applicant Has Applied for SUNY Downstate Financial Aid: ❑ Yes ❑ No

Financial Aid Grant/Scholarship: ❑ Approved ❑ Denied

_____ _____

Signature *Date*

If approved, Banner screen updates on SGASTDN made by:

_____ _____

Signature *Date*

Date completed form returned to Admissions for Applicant admissions file: _____