



# SUNY DOWNSTATE Medical Center

## EDUCATIONAL OPPORTUNITY PROGRAM (EOP) VERIFICATION FORM FOR UNDERGRADUATE PROGRAMS

### 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.

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#### 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. Applicants with a Baccalaureate degree are ineligible for EOP/SEEK/HEOP/College Discovery
4. Applicants are only eligible for 10 semesters of EOP/SEEK/HEOP/College Discovery.
5. You must apply for financial aid at SUNY Downstate

If you are accepted for admission at SUNY Downstate, all sections of the EOP Application Verification Form must be completed and returned 30 business days prior to your registration date at SUNY Downstate, in order to be considered for EOP benefits.

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#### 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

\_\_\_\_\_

Street

\_\_\_\_\_

Apt.

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip

\_\_\_\_\_

Telephone (Day)

\_\_\_\_\_

Telephone (Evening)

\_\_\_\_\_

Telephone (Cellular)

Have you received a bachelor's degree:

Yes  No

It is important that all sections are complete where appropriate.

**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*

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

Year of Admission: Fall \_\_\_\_\_ Spring \_\_\_\_\_ Summer \_\_\_\_\_

I applied for SUNY Downstate Financial Aid on \_\_\_\_\_  
*Date*

**Section 2. To be completed by prior institution's EOP/SEEK/HEOP/College Discovery Coordinator**

\_\_\_\_\_  
*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

Total Number of Semester's Student Received EOP/HEOP/SEEK: \_\_\_\_\_

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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 SGGASTNS made by:

\_\_\_\_\_  
*Signature* *Date*

Date completed form returned to Admissions for Applicant admissions file: \_\_\_\_\_