

2 PART B (TO BE COMPLETE BY THE COLLEGE or UNIVERSITY. PLEASE PRINT)

NAME OF INSTITUTION _____

CHECK ONE: **The applicant named above:**

(1) _____ Participated in the following opportunity program while attending this institution:

_____ EOP _____ HEOP _____ SEEK _____ College Discovery

_____ Other (Please explain) _____

DATES OF ENROLLMENT (Month/Year) From _____ To _____

TOTAL NUMBER OF SEMESTERS ENROLLED IN THE PROGRAM ABOVE: _____

Type of degree received or expected _____ Date: _____

Major Taken _____

(2) _____ **DID NOT** participate in the EOP or a similar opportunity program while attending this institution.

(3) _____ This institution does not offer an EOP-type program, but the student would have been eligible if such a program did exist here.

PREPARER'S NAME (PRINT)

TITLE

SIGNATURE

DATE

DEPARTMENT

PHONE NUMBER

PLEASE MAIL THIS FORM TO:

SUNY Downstate Medical Center
Office of Student Financial Aid
450 Clarkson Avenue, Box 110
Brooklyn, NY 11203-2098
Attn: Educational Opportunity Program
or fax to 718 270-7592