



# VisionQwest Healthcare

## Education / Credential Verification Form

This form is used to verify educational credentials using the National Student Clearinghouse, other official web-based educational verification services (e.g. CA Professional Boards), or directly with the educational institution.

TO: \_\_\_\_\_  
Education Institution or Credentialing Authority

FAX: \_\_\_\_\_

FROM: VisionQwest Healthcare – Staffing Coordinator

RE: Education / Credential Verification

\_\_\_\_\_

Student's Credentialed Individual's Name

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

To be completed by the applicant:

Applicant Authorization

I authorize VisionQwest Healthcare to verify my education / credentials.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Full Name: \_\_\_\_\_

Print maiden name or other name that may have been used during enrollment or on certification / licensure:

\_\_\_\_\_

To be completed by the Registrar or other authorized official:

Enrollment Date From \_\_\_\_\_ to \_\_\_\_\_

Hours Completed: Semester \_\_\_\_\_ Quarter \_\_\_\_\_

Did student receive a degree? (circle) YES NO

What degree? \_\_\_\_\_ Major \_\_\_\_\_ Minor \_\_\_\_\_

Did student receive a diploma? (circle) YES NO

Did student receive a certificate? (circle) YES NO

Registrar or Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_