

UPDATED CONTACT INFORMATION

(If name changed, two official verifying documents must accompany this form)

Name: _____ Effective Date: _____

Address: _____

Phone: _____ Cell Phone: _____

E-mail Address: _____@_____

Check One: () MS I () MS II () MS III () MS IV

Signature: _____ Date: _____

RETURN THIS FORM TO: Office of the Registrar
Edward Via Virginia College of Osteopathic Medicine
2265 Kraft Drive
Blacksburg, VA 24060

OR

kthorsen@vcom.vt.edu

**IF SENDING BY E-MAIL, YOU MUST TYPE YOUR NAME IN THE SIGNATURE LINE ABOVE
AND MUST SEND THIS FORM FROM THE E-MAIL ADDRESS WHICH IS ON FILE AT
VCOM. WE CAN NOT ACCEPT CHANGES SENT FROM OTHER E-MAIL ACCOUNTS.**

FOR OFFICE USE:

Registrar: _____
Business Office: _____

Financial Aid: _____
Other: _____