



ARKANSAS COLLEGE OF
OSTEOPATHIC MEDICINE
7000 Chad Colley Boulevard
Fort Smith, AR 72916

Office of Financial Aid
Phone: (479) 308-2209
Fax: (479) 308-2266
E-mail: financialaid@arcomedu.org

2017-2018 Certification Request for VA Benefits

Student Name: _____ Student Id #: _____

Complete this form to request certification of VA Benefits.

Section A. Complete current contact information

Mailing Address	
Physical Address	
E-Mail	
Telephone	

If your contact information changes, you must notify the Registrar and the Office of Financial Aid immediately.

Section B. Enrollment Information

Current Major: Degree of Osteopathic Medicine

Type of Degree: First Professional Degree

Anticipated Graduation Date: April 30, 2021

Section C. Benefit Information

1. Which benefit(s) will you be using:

- 30 (MGIB) 31 (VR&E) 33 (Post 9/11) 35 (DEA)
 1606 (Reserve) 1607 (REAP)

2. If you are using transferred entitlement, are you the spouse or child?

- SPOUSE CHILD

3. Are you on Active Duty?

- YES NO

4. If Guard or Reserve, are you using Tuition Assistance?

- YES NO

5. What is your status?

- New VA claimant Continuing student Transfer student
 Guest student (Permission to Enroll at Another Institution required)

Section D. Term and Course Information

Check the box for each term you wish to be certified for and complete information about each course:

Fall 2017

Course Prefix	Course Number	Course Title	Credit Hours	Applies to Degree (Y/N)	Comments	Note any remedial classes. Substitutions, waivers, etc., must be attached.

Spring 2018

Course Prefix	Course Number	Course Title	Credit Hours	Applies to Degree (Y/N)	Comments	Note any remedial classes. Substitutions, waivers, etc., must be attached.

Section E. Attach appropriate documentation

- Certificate of Eligibility** **DD-214** **Other**

Section F. Certification Statement

I certify the information above is true and I wish the Arkansas Colleges of Health Education to certify for the terms and courses indicated to the VA. I understand I am responsible to the Arkansas Colleges of Health Education for any tuition or fee charges the VA benefits do not cover. If I decide not to attend my classes, I am responsible for dropping them and I must notify the Office of Financial Aid of any schedule change(s). If I do not fulfill this obligation my benefits may be delayed. **If I drop any of my classes, I am required to return the funding that I have been provided.**

Student Signature: _____ Date: _____

For Administrative Use Only

Date Received:	_____	Active Duty:	YES	or	NO
Dependent:	YES or NO	Remedials:	YES	or	NO
Ch. 33 Tier:	_____%	Enrollment Status:	<1/2	1/2	3/4 FT
Awaiting:	COE DD-214	Credit Hours:	_____		
Actual Tuition/semester:	\$_____	Actual Fees/semester:	\$_____		
Reported Tuition/semester	\$_____	Reported Fees/semester:	\$_____		
Total Tuition & Fees/semester	\$_____				