Cleveland Clinic
School of Health Professions

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School of Health Professions

Custom Verification Worksheet (V4)
2026-2027

This information is required by the US Department of Education. Incomplete or incorrectly completed forms will be returned and delay the completion of your award.

Student Information

Name: _____ **SIS ID Number:** _____

Permanent Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____ **Date of Birth:** _____

Certification Statement
By signing below, I certify that:

- If I withdraw from the program, I understand that my aid may be REDUCED or CANCELED, and I may be responsible for repaying any federal funds.
- I understand that my aid will be disbursed based on my enrollment status and may be different from my award letter.
- I understand and will use any federal funds received under the Title IV financial aid programs or Federal Student Loans this award year solely for expenses related to my attendance at Cleveland Clinic's School of Health Professions.
- I understand that to be eligible for and to receive Federal Student Aid, I must be in an approved program at Cleveland Clinic's School of Health Professions.
- I have read and will comply with the information included in the school catalog.

Each person signing below certifies that all of the information reported is complete and correct. The student and one parent whose information was reported on the FAFSA **must** sign and date.

Print Name: _____ SIS ID Number: _____

Student Signature: _____ Date: _____

Signature of Parent (dependent students only): _____ Date: _____

Signature of Spouse (independent students only): _____ Date: _____

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Identity and Statement of Educational Purpose
This portion of the form cannot be signed or faxed.

(To Be Signed at Cleveland Clinic School of Health Professions)

The student must appear in person at Cleveland Clinic's School of Health Professions to verify his or her identity by presenting an unexpired valid government-issued photo identification (ID), such as, but not limited to, a driver's license, other state-issued ID, or passport. The school will maintain a copy of the student's photo ID that is annotated by the institution with the date it was received and reviewed, and the name of the official at the institution authorized to receive and review the student's ID. In addition, the student must sign, in the presence of a school official, the Statement of Educational Purpose provided below.

Attention:
If you are unable to appear in person at Cleveland Clinic's School of Health Professions, please see the next page.

Statement of Educational Purpose

I certify that I _____ am the individual signing
(Print Student's Name)

this Statement of Educational Purpose and that the Federal student financial assistance I may receive will only be used for educational purposes and to pay the cost of attending Cleveland Clinic's School of Health Professions for the 2026–2027 year.

_____ _____
Student's Signature Date

_____
SIS ID Number

_____ _____
School Official Signature Date

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Identification and Statement of Educational Purpose
This portion of the form cannot be scanned or faxed.

(To Be Signed by Notary)

If the student is unable to appear in person at SOHP to verify his or her identity, the student must provide to the institution:

1. A copy of the unexpired valid government-issued photo identification (ID) that is acknowledged in the notary statement below, or that is presented to a notary, such as, but not limited to, a driver's license, other state-issued ID, or passport; **AND**
2. The original Statement of Educational Purpose provided below, which must be notarized. If the notary statement appears on a separate page than the Statement of Educational Purpose, there must be a clear indication that the Statement of Educational Purpose was the document notarized.

Statement of Educational Purpose

I certify that _____ am the individual signing
(Print Student's Name)

this Statement of Educational Purpose and that the Federal student financial assistance I may receive will only be used for educational purposes and to pay the cost of attending Cleveland Clinic's School of Health Professions for the 2026–2027 year.

_____ _____
Student's Signature Date

_____
SIS ID Number

Notary's Certificate of Acknowledgement

State of _____
City/County of _____
On _____, before me,_____
(Date) (Notary's Name)
personally appeared,_____ , and proved to me
(Printed Name of Signer)
on the basis of satisfactory evidence of identification _____
(Type of Gov't-Issued ID)
to be the above-named person who signed the foregoing instrument.

WITNESS my hand and official seal

_____
(Notary Signature)

My commission expires on: _____