

Credential Request Authorization Form

Company/Organization name

Hope Training Academy

Today's date

10/27/2020

Applicant's information

Name while enrolled in the institution

Tia Schwarz

Date of birth

10/27/2020

Street address

800 State Road 212 A6

City

Michigan City

State/Province

IN

Postal code

46360

Email address

tiaschwarz6@gmail.com

Phone number

2195619031

Authorization

By signing this document, I authorize (enter receiving company/organization)

Hope Training Academy

to request (enter name(s) of institution(s) that has your credential)

AK Smith Center

to release my complete academic credential to (enter receiving company/organization)

Hope Training Academy

I certify under penalty of law that I am the individual identified in this credential request, or I am the parent/guardian authorized to make this request (sign below)

