



College of Public Health and Health Professions
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Request for UFID

Date:_____

Legal Name:_____

Date of Birth:_____

Personal Address:_____

Personal Phone Number:_____

Personal Email Address:_____

Gender: Male ☐ Female ☐

Have you ever been a student at UF? Yes ☐ No ☐

Have you ever been a Faculty, Staff, or OPS employee at UF? Yes ☐ No ☐

This section to be completed by Departmental Staff

Department Affiliation:_____Relationship end date:_____

Staff member name:_____