MARIAN UNIVERSITY
Indianapolis ®

Enrollment Verification Form
MU-COM DO Students ONLY
Allow 3-5 Business Days for Processing

Office of the Registrar 3200 Cold Spring Road, Indianapolis, IN 46222 Phone: 317.955.6050 Fax: 317.955.6575 Email: regis@marian.edu

Student Information: Please PRINT

Student Name: ____ MUHUB Student ID: _____________________

Email: ____ Phone Number: (______) ________ - _______

Semester (check semester, fill in year): ○ **Fall __________** ○ **Spring __________**

Delivery Options for individual/entity listed below: E-mail US Mail Fax

To: ____

Address: ____ Email Address: ___________________________________

____ Fax #: (_______) ________-__________

My signature below authorizes the Office of the Registrar at Marian University to send my verification to the person or organization listed above. FAX WARNING: I understand that by faxing this form, I will be compromising my confidentiality and release Marian University from any liability that may arise.

Signature: ____ Date:_________________________

*This document requires an original/legal signature. A typed in name will not be accepted as a signature.

REGISTRAR'S OFFICE USE ONLY BELOW

This is to certify that ____ was/is enrolled at Marian University College of Osteopathic Medicine:

Fall semester ______ for a total of _____ credits Semester Dates: _____/_____/_____ to _____/_____/_____

Spring semester ___ __ for a total of _ ___ credits Semester Dates: _____/_____/_____ to _____/_____/_____

Matriculation Date: _______/_______/_______ Expected Graduation Date: _______/_______/_______

Authorized Signature: ____

Name Printed: ____

Title: ____

Date: _______/_______/_______

Official School Seal