

Student Information: Please PRINT

Student name: _____ Last four digits of SS# or Student ID: _____

Previous Name: _____ Graduation Semester/Year: _____

Email: _____ Phone Number: (____) _____ - _____

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

To: _____

Address: _____

If faxing, fax #: (____) _____ - _____

My signature below authorizes the Office of the Registrar 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 **the above named student** matriculated in the College of Osteopathic Medicine at Marian University University and successfully completed all requirements and graduated with the Doctor of Osteopathic Medicine (D.O.) degree.

During his/her tenure as a student, _____ performed in a noteworthy manner—personally, professionally, and academically—and graduated in good standing.

Matriculation Date: ____/____/____ Dates of Attendance: ____/____/____ to ____/____/____

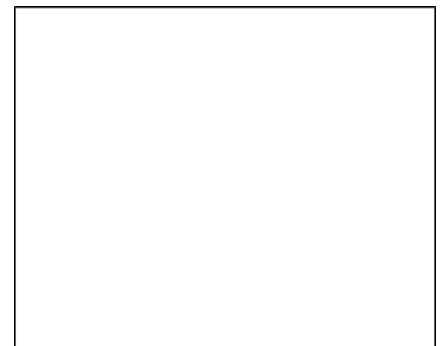
Graduation Date: ____/____/____

Authorized Signature: _____

Name Printed: _____

Title: _____

Date: ____/____/____



Official School Seal