Northeast Ohio MEDICAL UNIVERSITY

Office of the Registrar
Student Record Request Form

Date_____

NEOMED ID @_____ Program: MD ◯ PharmD ◯ COGS ◯ Class of:_____

_____

Last Name First Name Middle Name Previous Name(s)

_____

Street Address

_____

City State Zip

_____

Phone # Email Address Birthdate SS # (last four)

Documentation Request (Check all that apply):

- ☐ Printed Official Transcript (must pick-up in The Office of the Registrar)
- ☐ ERAS Transcript (M4 Grads only)
- ☐ VSLO/VSAS Transcript (M3 only)
- ☐ MSPE/Dean's Letter (Grads Only)
- ☐ Certified Diploma
- ☐ Other_____
- ☐ Letter (Check all that apply):
  - ☐ Good Standing
  - ☐ Scholarship
  - ☐ Jury Duty
  - ☐ Research
  - ☐ Nomination/Membership
  - ☐ Elective Application
  - ☐ Employment
  - ☐ Insurance Purposes
  - ☐ Landlord
  - ☐ Residency
  - ☐ Other (be specific)_____

Information to include in letter:

- ☐ Academic Status
- ☐ Malpractice Insurance Info
- ☐ Graduation Date
- ☐ Other (be specfic)_____
- ☐ Enrollment Status

Documentation Delivery Method:

- ☐ Please email to: _____
- ☐ Please fax to: _____
- ☐ I will pick up documentation in the Office of the Registrar (Room R-121)
- ☐ Please mail to: _____
  _____
  _____

Special Instructions:

Student /Alumni Signature

My signature below authorizes release of this information as indicated on the form and I certify all the information I provided is true and accurate.

_____

Signature Date

REQUESTS SHOULD BE SUBMITTED AT LEAST TWO WEEKS BEFORE NEEDED.

Return this form to: registrar@neomed.edu or Fax: 330-325-5905 or mail to:

Northeast Ohio Medical University
Office of the Registrar
PO Box 95
Rootstown, OH 44272