MARIAN UNIVERSITY
Indianapolis ®

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

Office of the Registrar 3200 Cold Spring Rd., Indianapolis, IN 46222 317.955.6050 fax: 317.955.6575 email: regis@marian.edu

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

Last updated March 2017