

Allow 3-5 Business Days for Processing

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

Student Information: Please PRINT

Student Name: _____ MUHUB Student ID: _____
Student Email : _____ Student Phone Number: (_____) _____ - _____

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

Delivery options for individual/entity: **Emailed** **Mailed via USPS**

To Individual/Entity: _____

Email: _____

Mailing Address: _____

My signature below authorizes the Office of the Registrar at Marian University to send my verification to the person or organization listed above.

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 **(insert name of student)** was/is enrolled at Marian University in the Wood College of Osteopathic Medicine.

Fall **year - ##** credits Semester Dates: **insert start date** to **insert end date**

Spring **year - ##** credits Semester Dates: **insert start date** to **insert end date**

Matriculation Date: **insert date**

Expected Graduation Date: **insert date**

Authorized Signature: _____

Name Printed: **insert printed name**

Title: **insert job title**

Date: **insert date**



Official School Seal