

**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:**     Emailed                       Mailed via USPS

To Individual/Entity: \_\_\_\_\_

Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

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

During his/her tenure as a student at MU-WCOM, *(insert name of student)* performed in a noteworthy manner—personally, professionally, and academically—and graduated in good standing.

Matriculation Date: *insert date*                      Dates of Attendance: *insert date to insert date*

Graduation Date: *insert date*

Authorized Signature: \_\_\_\_\_

Name Printed: *insert printed name*

Title: *insert job title*

Date: *insert date*

Special Notes: *(if applicable)*



Official School Seal