

Office of the Registrar 3200 Cold Spring Road, Indianapolis, IN 46222 Phone: 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: _____

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

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

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

To: _____

Address: _____ Email Address: _____

_____ Fax #: (____) _____ - _____

My signature below authorizes the Office of the Registrar at Marian University 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 _____ was/is enrolled at Marian University
College of Osteopathic Medicine:

Fall semester _____ for a total of _____ credits Semester Dates: ____/____/____ to ____/____/____

Spring semester _____ for a total of _____ credits Semester Dates: ____/____/____ to ____/____/____

Matriculation Date: ____/____/____

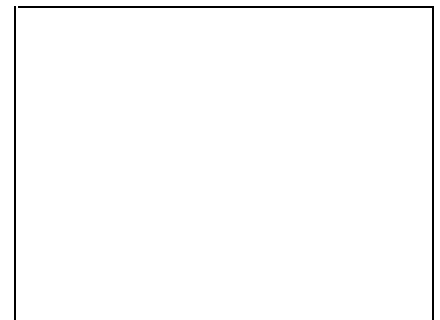
Expected Graduation Date: ____/____/____

Authorized Signature: _____

Name Printed: _____

Title: _____

Date: ____/____/____



Official School Seal