



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

Documentation Request (Check all that apply):

- Official Transcript -with NEOMED Login (electronic or printed)
Official Transcript - without NEOMED Login (electronic or printed)
ERAS Transcript (M4/Grad)
VSLO/VSAS Transcript (M3 Only)
Printed Official Transcript (MUST pick up in the Office of the Registrar)
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 specific) _____
Enrollment Status

Documentation Delivery Method:

Please email to: _____ Please mail to: _____

Please fax to: _____

I will pick up documentation in the Office of the Registrar (Room R-121)

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