Northeast Ohio
MEDICAL UNIVERSITY

Office of the Registrar
Student Record Request Form

1. **General Information**

Date of request Date needed Email

Banner ID@ Birthdate SSN XXX-XX-

Full Name (Last, First, Middle) Maiden Name (if applicable)

Address (Alumni only)

(Number and Street)

Phone Number

(City, State, Zip Code)

Program: MD PharmD COGS Class of

2. **Documentation Request (check all that apply)**

Transcript Choose one: Official Unofficial Electronic

ERAS Transcript(M4/grads only) Certified Diploma

MSPE/Dean's Letter(grads only) Other

Letter of Good Standing (check all that apply)

elective application
employment
fellowship application
insurance purposes
jury duty
landlord
nomination/membership
research
residency
scholarship
other (please name)

Information to Include in Letter (check all that apply)

academic good standing
malpractice insurance coverage
other (be specific)
enrollment status projected
graduation date

3. **Method of Response to Requester** ***(address of recipient if other than requester on next page)*****:**

I will pick up this documentation in the Office of the Registrar.

We will e-mail you once your request has been completed

Please email to:

Please fax to:

Please mail to:

Special Instructions:

4. **Student/Requester 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 WILL BE PROCESSED FREE OF CHARGE AND SHOULD BE SUBMITTED AT LEAST TWO WEEKS BEFORE NEEDED.

Return this form to: Northeast Ohio Medical University or registrar@neomed.edu or Fax: 330-325-5905
Office of the Registrar
PO Box 95
Rootstown, OH 44272

Student/Graduate Name:

Please print or type below the name of each individual/institution you wish to receive a copy of your documentation. *****Email and Fax are only needed if you are choosing that way for transmittal.***

Name

Title

Department

Hospital/Institution

Address

City/State/Zip

**Email

**Fax Number

Name

Title

Department

Hospital/Institution

Address

City/State/Zip

**Email

**Fax Number

Name

Title

Department

Hospital/Institution

Address

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