



Edward Via College of Osteopathic Medicine

AUBURN

Document Request

Student Name: _____ DOB: _____
(Full Name - Former Students use name attended under)

E-mail: _____ Phone #: _____
(Current Students use VCOM E-mail)

Class Year: 20_____

Current Status:

Current Student Graduate Non-Graduate

1. Transcript Request:

Official Transcript Unofficial Transcript (Non-Graduate only, all others use SIS)

Pick-Up Mail E-mail (Unofficial Only) Fax- #: _____ Number of Copies _____

Attention/Office _____

Company/Institution _____

Address/PO Box _____

City, State, Zip _____

2. Letter Certifying Enrollment Request

Pick-Up Mail E-mail (School SEAL not included) Fax- #: _____ Number of Copies _____

Attention/Office _____

Company/Institution _____

Address/PO Box _____

City, State, Zip _____

3. Other: Please describe request _____

Pick-Up Mail Fax- #: _____ Number of Copies _____

Attention/Office _____

Company/Institution _____

Street Address/PO Box _____

City, State, Zip _____

Student Signature: _____ Date: _____

For Office use only: Authorized initials: _____ Date Completed: _____ Date Mailed: _____ Amount Paid: _____