Washington University in St. Louis
School of Medicine

Document Request Form

____
Full Name (please print):

____
Name While Attending (If different)

____
Student ID Number (or last four of SSN if not known)

____
Date of Birth

____
Program Attended

____
Dates of Attendance

Select requested documents:

☐ Copy of diploma (with translation, if MD)

This is a PDF version. For a formal copy of your diploma, please visit the replacement diploma page at https://registrar.wustl.edu/student-records/graduation/diplomas/

☐ Enrollment Verification

☐Degree Verification Letter

☐ Enrollment Verification Letter

☐ Other*: ____

***Please do not use this form to request transcripts. For instructions on how to request a transcript, visit: https://registrar.med.wustl.edu/services/transcripts-and-certification/**

Please send the requested documents to:

Name/Organization/Institution _______________________________________

Street Address ____

City, State, Zip Code ____

Email Address ____

By signing below you authorize Washington University School of Medicine in St. Louis to release documents indicated above.

____
Student's Signature

____
Date

Please scan and return via email to wusmregistrar@wustl.edu