

\_\_\_\_\_  
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/students/transcripts/>**

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](mailto:wusmregistrar@wustl.edu)