

NEW YORK COLLEGE OF PODIATRIC MEDICINE
1800 Park Avenue • New York, NY 10035
Office of Records and Registration
(212) 410-8054

REQUEST FOR REGISTRAR SERVICE

Instructions: Print clearly, completing all sections that apply. You must sign and date this form. Issue check or money order payable to New York College of Podiatric Medicine (see fees below). Requests will be filled in the order received unless fee is paid for special handling. A confirmation of the completed transaction will be provided. (Do NOT use this form for transcript request)

Name: Last _____ First _____ M.I. _____ Social Security Number _____
_____-_____-_____
Mailing address (Number & Street, City, State, Zip Code) _____
Student ID #: _____
Local Phone: _____ Home Phone: _____ Student Mailbox: _____
if different: _____

Check status:

- Student/former student (not graduate)** **Graduate**
 Currently enrolled Graduation Date: _____
 Not currently enrolled: Last term of Enrollment was Sem. ____ Year ____

Service(s) Requested:

- | | |
|---|---------------------|
| <input type="checkbox"/> National Board Scores (<u>enrolled student only</u>) | Fee: \$5.00 |
| <input type="checkbox"/> Clinical Evaluation alone | no charge |
| <input type="checkbox"/> Clinical Evaluation with transcript (use transcript request) | transcript fee only |
| <input type="checkbox"/> Verification of Education* | \$10.00 |
| <input type="checkbox"/> Duplicate Diploma (requires affidavit of loss) | \$85.00 |
| <input type="checkbox"/> Special Handling (priority processing + Express Mail) | \$18.00 |

*specify: Current Enrollment Good Standing Completion of ____ Year ____ DPM degree
For additional statements, use "Request for Statement" form

Signature _____ Date _____

- I will pick up Mail to Addressee: _____
 FAX to Addressee: _____

| |
|--|
| Office use only: <input type="checkbox"/> fees received <input type="checkbox"/> Signature verified Transaction completed and mailed on _____ |
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