REQUEST FOR VERIFICATION OF GRADUATION

NAME: _____ **SIGNATURE:** _____

EMAIL: _____ **DATE:** _____

B.U. ID# or Date of Birth: _____

DATE OF GRADUATION: _____

_____ **Verification of Graduation**

_____ **Diploma Translation**

_____ **Photocopy of Diploma (Class of 1997 or later)**

Please send document(s) to the following Email or U.S. Mailing address:

_____

_____

_____

_____

Completed request forms should be sent to:
Email: camedreg@bu.edu
U.S. Mail: Boston University Chobanian & Avedisian School of Medicine
The Office of the Registrar
72 E. Concord Street, Room A414
Boston, MA 02118
Fax: (617) 358-7551