

**Michigan State University College of Osteopathic Medicine**

**Registrar's Office**

965 Wilson Road, Suite C110  
East Lansing, MI 48824-1316  
Phone: 517-353-7741 – Fax: 517-432-1976

**Graduation Verification Form**

**Instructions:**

Complete form and submit to  
[OsteoMedReg@hc.msu.edu](mailto:OsteoMedReg@hc.msu.edu)

**Allow 7-10 Business Days for Processing**

**Student Information: Please PRINT**

Student name: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Name: \_\_\_\_\_ Graduation Year: \_\_\_\_\_ Last four digits of SS# \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Delivery Options for individual/entity listed below:**      E-mail      US Mail      Fax

To: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

If faxing, fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

My signature below authorizes the Office of the Registrar at MSUCOM to send my verification to the person or organization listed above. FAX WARNING: I understand that by faxing this form, I will be compromising my confidentiality and release MSUCOM from any liability that may arise.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REGISTRAR'S Office USE ONLY BELOW**

This is to certify that **the above named student** matriculated in the College of Osteopathic Medicine at Michigan State University and successfully completed all requirements and graduated with the Doctor of Osteopathy/Doctor of Osteopathic Medicine (D.O.) degree.

During his/her tenure as a student in this College, \_\_\_\_\_ performed in a noteworthy manner—personally, professionally, and academically—and graduated in good standing.

Matriculation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      Dates of Attendance: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Graduation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Authorized Signature: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Official School Seal