

## IUSM Graduate Records Request (not for use by current students)

*This form is for medical school credentials only. For fellowship and residency verification, see [Graduate Medical Education](#).*

Name\*: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*All name changes require legal documentation

Last name used while enrolled in Medical School: \_\_\_\_\_ Year of graduation: \_\_\_\_\_

Social Security - last 4 only: XXX-XX-\_\_\_\_\_

Date of Birth (mm/dd/yyyy)\_\_\_\_\_

Telephone Number \_\_\_\_\_

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

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Email address for confirmation purposes: \_\_\_\_\_

### Item Requested:

\_\_\_\_ Transcript - \$10.00 each

\_\_\_\_ Dean's Letter (This is the letter written for you for Residency)

\_\_\_\_ State Licensure form (graduate must provide)

\_\_\_\_ Certified copy of diploma (graduate *must* provide a photo copy)

\_\_\_\_ Other: Please explain \_\_\_\_\_

***Make check payable to IUSM. No cash please. Request receipt if needed.***

Signature\* \_\_\_\_\_ Date \_\_\_\_\_

**\*Signature required to process all records requests. Please allow at least ten working days for processing.**

List one or two addressees here: *(Note for more than two addressees please email list to [kchamp@iupui.edu](mailto:kchamp@iupui.edu).)*

Name and address of recipient #1

Name and address of recipient #2

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**Please mail this form to:** Graduate Credentialing; Medical Student Affairs- IUSM; 635 Barnhill Drive, MS 160; Indianapolis, IN 46202 Phone: (317) 274-7895; Fax: (317) 278-4755; Email: [kchamp@iupui.edu](mailto:kchamp@iupui.edu)