



**Office of the Registrar, Room S1-844**  
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**Document Request Form**

Please type or print information clearly  
 This form may be returned via fax or postal mail  
**This form must be signed**

Transcript (Official) # of Copies \_\_\_\_\_

Transcript (Unofficial/Student Copy) # of Copies \_\_\_\_\_

Enrollment Verification Letter # of Copies \_\_\_\_\_

Copy of Diploma # of Copies \_\_\_\_\_

MSPE (Dean's Letter) # of Copies \_\_\_\_\_

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**Name** \_\_\_\_\_ **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **DOB** \_\_\_\_\_

**Program (check all that apply)** School of Medicine \_\_\_\_\_ Graduate School of Biomedical Sciences \_\_\_\_\_ Graduate School of Nursing \_\_\_\_\_

**Year of Graduation** \_\_\_\_\_ **Dates of Attendance** \_\_\_\_\_

**Send Requested Documents To:** Address Below \_\_\_\_\_ Student Mailbox # \_\_\_\_\_ Pick Up By (name) \_\_\_\_\_

(Use the back of this form if additional space is needed)

1 \_\_\_\_\_  
 (Name) (Street Address) (City) (State) (Zip Code)

2 \_\_\_\_\_  
 (Name) (Street Address) (City) (State) (Zip Code)

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

**GRADUATES, PLEASE PROVIDE THE FOLLOWING INFORMATION**

Former name(s) used on university records \_\_\_\_\_

**(We are required by the Commonwealth of Massachusetts to keep records of where our graduates did post-graduate training and where they are presently practicing)**

Are you currently in residency/fellowship training? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, program name \_\_\_\_\_

Program address \_\_\_\_\_  
 (Street Address) (City) (State) (Zip Code)

Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_ Are you a practicing physician? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is your specialty? \_\_\_\_\_ Name of facility where you are practicing \_\_\_\_\_

Address \_\_\_\_\_  
 (Street Address) (City) (State) (Zip Code)

Website: www. \_\_\_\_\_

Your E-mail \_\_\_\_\_@\_\_\_\_\_

**This information may be shared with the UMMS Office of Alumni Affairs.** Yes \_\_\_\_\_ No \_\_\_\_\_