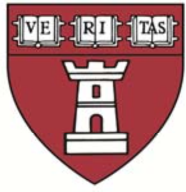

HARVARD School of Dental Medicine

Alumni Transcript / Graduation Verification Request Form

(Requests are generally processed within-in 5-7 business days after receipt)

I am requesting ____ copy(ies) of the following document(s):

___ HSDM *Official* Transcript*

There is a **$3 fee** per transcript, per program. At this time, we only accept cash or check.
Transcripts are not be processed until after payment has been received.
Make check payable to **HSDM** and mail request to:

Harvard School of Dental Medicine
Attn: Registrar's Office, Transcript Request
188 Longwood Avenue
Boston, MA 02115

___ Graduation Verification Letter

___ Form(s) to be completed (include details in space below)

Instructions:

__ Will pick-up from Registrar's Office.

__ Mail to: ____

____

____

__ Fax to: ____

For the purpose of: ____

Please Print Clearly

Name: ____

* Indicate any other names used while an enrolled student (e.g. maiden name, legal name change) *

Program and Graduation Year: ____

Signature: ______________________________ Date: ________________

Email: ______________________________ Phone: ________________