

IUSM Graduate Records Request Form

(NOT for use by current students)

For fellowship and residency verification, see [Graduate Medical Education](#). This form is for Medical Degree (M.D.) credentialing only.

Name*: Last _____ First _____ Middle _____

*All name changes require legal documentation

Last name used while enrolled in Medical School: _____ Year of grad. _____

Date of Birth (mm/dd/yyyy) _____

Telephone Number _____

Street Address: _____

City _____

State _____

Zip _____

Email address for confirmation purposes:

Item Requested:

Transcript - \$15.00 each

Dean's Letter/MSPE (This is the letter written for you for Residency)

State Licensure form (graduate must provide)

Certified copy of diploma (graduate must provide 8 1/2 x 11 copy to be certified)

Other: Please explain _____

Please have form filled out and sent via e-mail attachment to medcred@iu.edu. If you are requesting a transcript please look for a response e-mail with an online payment link once your form has been submitted.

Signature* _____ Date _____

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

Please list addressees here: (*NOTE: For more than two addressees please email list to medcred@iu.edu.)*)

Name and address of destination 1:

Name and address of destination 2:

_____	_____
_____	_____
_____	_____
_____	_____

If you need to send this form by mail please e-mail medcred@iu.edu for the correct address.