

203 Rowland Hall · 4190 City Ave · Philadelphia, PA 19131
Tel: 215-871-6704 · Fax: 215-871-6649 · registrar@pcom.edu · www.pcom.edu

Student Information: Please PRINT

Name: _____ SSN/Banner ID: _____

Previous Name: _____ Graduation Year: _____

Program: _____ Date of Birth (mm/dd/yyyy): ____/____/____

Email: _____ Phone Number: (____)____ - _____

Delivery Options: Pick up Mail Fax

To: _____ If Faxing, Fax #: _____

Address: _____

My signature below authorizes the Office of the Registrar at PCOM 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 PCOM from any liability that may arise.

Signature: _____ Date: _____

REGISTRAR'S OFFICE USE ONLY BELOW

This is to certify that the above named student is enrolled at: Philadelphia Campus Georgia Campus

Date Degree Awarded: ____/____/____ OR Expected Graduation Date: ____/____/____

Degree Upon Graduation:

- Doctor of Osteopathy Doctor of Osteopathic Medicine Doctor of Psychology Master of Science
 Education Specialist Post-Doctorate Certificate Certificate of Adv Grad Studies Certificate
 Other _____

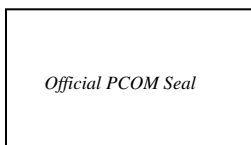
Major:

- Applied Behav Analysis (Psych) Biomedical Sciences Clinical Health Psych Clinical Psychology
 Clinical Neuropsychology Cognitive Behav Therapy Couns & Clin Hlth Psych Forensic Med
 Organizational Dev & Leadership Physician Assistant Studies Professional Psych School Psychology
 Other _____

This form is deemed official with the Verifying Official's Signature and PCOM Seal Affixed Below:

If this form is faxed to you from the Registrar's Office, 215-871-6649, the PCOM seal will not show, but is still valid.

School Code



Official PCOM Seal

Verifying Official's Printed Name

Verifying Official's Signature

Title

Date