

Philadelphia College of Osteopathic Medicine

Registrar's Office · Philadelphia and Georgia Campuses

Graduation Verification Form

3-5 Business Days for Processing

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: _____

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 South Georgia

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

Degree Upon Graduation:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Doctor of Osteopathic Medicine | <input type="checkbox"/> Doctor of Psychology | <input type="checkbox"/> Master of Science | <input type="checkbox"/> Education Specialist |
| <input type="checkbox"/> Post-Doctorate Certificate | <input type="checkbox"/> Certificate of Adv Grad Studies | <input type="checkbox"/> Certificate | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Doctor of Pharmacy | <input type="checkbox"/> Doctor of Physical Therapy | <input type="checkbox"/> Doctor of Philosophy | |

Major:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Applied Behav Analysis (Psych) | <input type="checkbox"/> Biomedical Sciences | <input type="checkbox"/> Clinical Health Psych | <input type="checkbox"/> Clinical Psychology |
| <input type="checkbox"/> Clinical Neuropsychology | <input type="checkbox"/> Cognitive Behav Therapy | <input type="checkbox"/> Couns & Clin Hlth Psych | <input type="checkbox"/> Forensic Med |
| <input type="checkbox"/> Organizational Dev & Leadership | <input type="checkbox"/> Physician Assistant Studies | <input type="checkbox"/> Professional Psych | <input type="checkbox"/> School Psychology |
| <input type="checkbox"/> Educational Psychology | <input type="checkbox"/> Mental Health Couns | <input type="checkbox"/> Public Health Mgmt | <input type="checkbox"/> Other _____ |

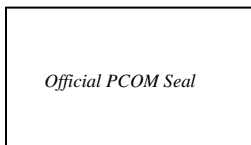
This form is deemed official with the Verifying Official's Signature and PCOM Seal Affixed Below:

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

Verifying Official's Printed Name

Title



Verifying Official's Signature

Date