HARVARD
School of Dental Medicine

Verification Request Form

◊ Requests are generally processed within **5 - 7 business days** after being received by Registrar Services; however, during certain times of year, processing may take longer

1. Your Information

Name: _____

☐ DMD ☐ DMSc ☐ MMSc ☐ Certificate Only

Former Name (if applicable): _____

AGE Specialty:
(if applicable) _____

Did you complete the program? ☐ Y   ☐ N

(Expected) Graduation Year: _____

2. Service Requested

Verification Letter (enrollment dates & program; program standing if applicable)	Qty: ___	**Form to be Completed** (fill out your section and attach form to your request for us to complete)	Qty: ___	**Other Letter/Request** (please explain under Additional Information)	Qty: ___

3. Delivery

☐ **Pickup**

☐ **Mail** (standard USPS)   ☐ **Fax,** Number_____

_____   _____

Recipient Name

_____   _____

Company/Institution Name

_____

Address for Mailing Request Only

_____

City   State   ZIP/Postal Code   Country (if outside of U.S.)

Additional Information: _____

4. Signature

I authorize the release of the requested information to the parties stated above:

X_____

Signature   Date

OFFICE USE ONLY

DATE RECEIVED: DATE COMPLETED: