Office of Student Life
Student Records
155D Meiling Hall
370 West 9th Avenue
Columbus, OH 43210

Requests will be processed within 10 business days.
Please return this form via fax or e-mail:
Fax: (614) 247-7959
medregistrar@osumc.edu

MEDICAL LICENSURE AND VERIFICATION REQUEST FORM

I, the undersigned, hereby authorize The Ohio State University College of Medicine and its Staff to provide any and all information pertaining to my medical education at their institution.

Signature ______________________ Date ______________

Name (Last, First, Middle)

Name At Time Of Graduation (if different from above)

Date Of Birth (MM/DD/YYYY) **Date Of Graduation** (MM/YYYY)

Preferred E-Mail Address **Phone Number** (xxx-xxx-xxxx)

Mailing Address (Street Address, City, State, Zip Code)

DELIVERY INSTRUCTIONS: Please select one delivery option.

E-mail Requested Documents to:			
Recipient's name (if available):		Recipient's email address:	

Fax Requested Documents to:			
Recipient's name (if available):		Fax Number (xxx-xxx-xxxx)	

Mail Requested Documents to: TEMPORARILY UNAVAILABLE			
Recipient's name (if available):			
Address:			
City, State, Zip Code			

All transcript requests must be submitted to the University Registrar's Office. Please visit https://registrar.osu.edu/alumni/index_transcript.asp to request a transcript.