MOREHOUSE
SCHOOL OF MEDICINE

Transcript/Diploma Request Form

Name: ____ Date: __________________

Student ID #: ______________ Email or Phone: ____

Type of Transcript
☐ Official ☐ Unofficial ☐ **Certified Diploma**

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Student Signature: ____

Morehouse School of Medicine – Office of the Registrar – 720 Westview Drive, Atlanta, GA 30310
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