Office of the Registrar, Room 1-212
PO Box 33932
1501 Kings Hwy.
Shreveport, LA 71130-3932
Phone: 318.675.5205
Fax: 318.675.4758
Email: shvreg@lsuhsc.edu

Office of the Registrar
Services Request Form

Student Information

Last Name: ________________________
First/M.I.: ________________________

Student ID#: ________________________

Current address: ________________________
____

Contact #: ______________________________

Email: ________________________________

Graduation Date: _______________

➢ ***Check the school you attended/attending***:

☐ School of Allied Health Professions — BS/MPAS/MOT/DPT/MPH/MCD

☐ School of Graduate Studies — MS/Ph.D.

☐ School of Medicine — M.D.

Request information

☐ Certified copy of diploma
(only available for graduates 1997 – current)
☐ Dean's Letter (MSPE)

☐ **Please mail:**
Include Name and Complete Address of Person/Place where information should be sent: (Attach additional pages if necessary)

____
____
____
____
____
____
____

Signature: ___________________________________ Date: _______________________

For Office Use Only

Date Sent: ___________ ☐ Mailed ☐ Faxed Initials: _______ Date of Pick-up: ______ Initials: ______