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DEGREE VERIFICATION REQUEST FORM FOR RSDM (NJDS) ALUMNI

Please complete the information below, sign, and e-mail this form, along with any forms to be completed, to enrollmentservices@sdm.rutgers.edu, to request a degree verification from Rutgers School of Dental Medicine (formerly UMDNJ-New Jersey Dental School). Requests are processed within 5-7 business days.

CONTACT INFORMATION		
Last Name	First Name	Middle Name
Email Address		
Phone Number (please enter numbers only	Student ID# (i.e., A00123456) if k	known
RSDM PROGRAM(S)		
Master of Dental Science/M	ntics Pediatric Dentistry Periodon laster of Science (Program in Dentistry) In axillofacial Surgery should contact Ms. Kisha Wes	MDS/MSD, Oral Facial Pain
REQUEST TYPE		
Degree/Graduation Conferral – Dean's Letter – When did you gr Other In your form submission e-mail, please	m — When did you graduate? (Month & Year) When did you graduate? (Month & Year) raduate? (Month & Year) include any special instructions with your request Please be sure to complete the personal information of the form.	t, and/or any external forms needed to
DELIVERY OPTIONS		
E-MAIL FAX MAIL Note: completed requests are mailed throug	gh USPS, therefore, we cannot provide mailing trackin	
Please E-MAIL my verification letter	Please MAIL my verification letter to the following mailing address:	Please FAX my verification letter to the following number:
to the following e-mail address:	the following mailing address:	Ţ,
		Attention:
		Fax #:
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Alumni Signature (Required)	Dat	e