Weill Cornell Medical College

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MEDICAL SCHOOL
CREDENTIALING REQUEST FORM

(Last Name while enrolled at WCMC/Cornell) First name Middle name

Street Address

City State Zip Code

(_____) _____-_____ _____
Phone Email Address

Date of Birth (mm/dd/yyyy) Year of Graduation Date of Request

Live signature needed. Sign on this line

Live Signature (Electronic Signatures NOT accepted)

☐ License application ☐ Letter of enrollment ☐ Attendance/Graduation Verification

☐ Loan deferment ☐ Official transcript ☐ Unofficial transcript

☐ Dean's letter/MSPE ☐ ___Certified Diplomas

☐ Other (please describe):_____

METHODS OF FULFILLMENT:

☐ PLEASE FAX TO: (_____) _____- _____

☐ I WILL PICK-UP DOCUMENTS

☐ PLEASE MAIL DOCUMENT(S) TO THE FOLLOWING ADDRESS:
If you have more than 1 address, please attach an additional page, with typed addresses.

FOR OFFICE USE ONLY:

Date Received:_____ Date Processed: _____