**Office of the Registrar**
**1501 Kings Hwy.**
**Shreveport, LA 71130-3932**
**Email: registrar@lsuhs.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

☐ School of Graduate Studies

☐ School of Medicine

**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: _____

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***For Office Use Only***

Date Sent: _____ ☐ Mailed ☐ Faxed Initials: _____ Date of Pick-up: _____ Initials: _____