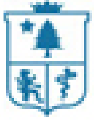

REQUEST FOR DIPLOMA OR CERTIFICATE COPY

Today's Date: ______________________

Student ID#: ______________________

Birthdate:______________________

Graduation Date: ______________________

Please select your program:

- ☐ Acupuncture/Oriental Medicine
- ☐ Chiropractic
- ☐ Massage Therapy
- ☐ Nutrition
- ☐ Undergraduate Health Sciences
- ☐ Other ______________________

Name: ____

Address: ____

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Phone: ____

Email: ____

Graduation Date: ______________________

Student Signature*: ______________________________Date: __________

**Please note: Your actual signature is required here.*

Send to: ______________________________________

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Return the completed form by any of the following methods:

Fax: 952-887-1386
Email: registrar1@nwhealth.edu
Mailing address: Northwestern Health Sciences University
Office of the Registrar/Student Financial Services
2501 West 84th Street
Bloomington, MN 55431

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