NEW YORK MEDICAL COLLEGE
A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM
Office of the University Registrar
40 Sunshine Cottage Road, Valhalla, New York 10595 Registrar@nymc.edu

Certification Request

Student Name: _____ ID#: _____

Email: _____ Contact #: _____

Please Check One:

❑ Basic Medical Sciences
❑ School of Health Sciences & Practice
❑ Medical School Class of: (YYYY)_____

Special/Additional information Request:

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Pick Up Instructions:

❑Letter to be picked up
❑Mail letter to:

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❑Letter to be emailed to:

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❑Letter to be faxed to:

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Signature: _____ Date: _____

FOR OFFICE USE ONLY

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