

REQUEST FOR CERTIFICATION
Harvard School of Public Health

Instructions: Please complete form legibly. Processing time is 5-7 BUSINESS days.

Student Information

Name: _____ **Harvard I.D. #:** _____

Date: _____ **Phone number:** _____

Are you currently enrolled at HSPH? Yes. Degree Program/Department: _____

No. Date of Enrollment: _____

Request

Please check the appropriate certification option(s):

Certification of Enrollment for the following dates: _____

Note: Students can only be certified for those semesters for which they are officially enrolled.

Certification of Graduation from HSPH.

Degree Received: _____

Department: _____

Graduation Date: _____

Expected to Graduate from HSPH.

Expected Degree: _____

Department: _____

Expected Graduation Date: _____

Completion of Academic Requirements Certification.

Certification of Tuition and Fees.

Please specify which items you wish outlined in the certification letter. The letter will be stamped with the HSPH Official Seal.

University Health Services

Blue Cross/Blue Shield

Fall HSPH Tuition

Spring HSPH Tuition

Registration Fee

Other _____

Certification of Other: _____

Handling

How many letters of certification are you requesting? _____

I will pick up my certification at the HSPH Registrar's Office

Please mail my certification to the following address: _____

OFFICE USE ONLY

Date Certification Completed: _____

Initials: _____

File: _____