



Goldman School of Dental Medicine

Office of the Registrar

Certificate of Enrollment Request Form

100 East Newton Street, G-428, Boston, MA 02118

Tel: 617-638-4708 | Fax: 617-638-4732

<http://dentalschool.bu.edu/registrar>

\_\_\_\_\_ date

\_\_\_\_\_ name

\_\_\_\_\_ BU ID

\_\_\_\_\_ phone number

\_\_\_\_\_ signature

number of copies \_\_\_\_\_

please check \_\_\_\_\_ pick up

\_\_\_\_\_ fax to (fax number): \_\_\_\_\_

\_\_\_\_\_ send to (address): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ENROLLMENT REQUESTS ARE PROCESSED WITHIN 2-3 DAYS OF THE RECEIPT OF THE REQUEST.**