



**ERAS REQUEST
AOA & MD Programs
Academics Records Request Form**

Kansas City University of Medicine and Biosciences
Registrar's Office
1750 Independence Avenue
Kansas City, MO 64106-1453
Phone: 816-654-7190 Fax: 816-654-7191

Name: _____
Graduation year or Last Date of Attendance: _____
Street: _____
City: _____
Home Phone: _____

S.S.# (last 4 digits): _____
E-mail: _____
Apt. #: _____
State: _____ Zip: _____
Cell Phone: _____

	Picture (While not required, a picture is highly recommended and should be of you in professional attire)
X	Official Transcript \$5.00 charge. No transcript will be issued for a student whose financial obligations to the college have not been satisfied. (ONE TRANSCRIPT IS ALL THAT IS NEEDED FOR ERAS).
X	Recommendation Letters
X	MSPE/ Dean Letter

By signing below, I authorize the KCUMB Registrar's Office to release my educational records, as indicated above, to the ERAS PROGRAM for participation in the Internship and Residency Match process.

Student Signature: _____

Note: Complete and sign form and send to the Registrar's Office.
Payment of \$5.00 for Official Transcript MUST accompany request. Check, Money Order or Cash Only.

Contact Information:

For Registrar Questions:

Dorothy Phelps 816-654-7194
Connie Weekley 816-654-7195
Cheryl Williams 816-654-7193
Heidi Terry, Registrar 816-654-7152

For MSPE / Dean's Letter Questions:

Allison Moore 816-654-7204
Cheryl Williams 816-654-7193

Office Use Only:

Date Received:	Date Processed:	Check #:	Check Amt:	Cash Amt
Date to Dean's Office:	Date Processed:	Check #:	Check Amt:	Cash Amt