LPU-ST. CABRINI SCHOOL OF HEALTH SCIENCES, INC.
COLLEGE OF ALLIED MEDICINE

Km. 54 National Highway Makiling, Calamba City, Laguna

OFFICE OF THE REGISTRAR

Tel No. (049) 502-0975

REQUEST FORM – ASSESSMENT / OTHER CERTIFICATE/S / CERTIFIED TRUE COPY OF DOCUMENTS
(ENROLLED STUDENTS)

Name of Student _____ Student Number _____

(Last Name) (First Name) (Middle Name) Contact No. _____

Course / Program: _____

Please check requested document/s:

( ) Grade Slip

_____Semester S.Y._____-_____\

( ) Certified True Copy of Registration Form

_____Semester S.Y._____- _____

( ) Certificate of Enrolment ( ) Certificate of Grades
( ) Checklist
( ) Others / Please specify: _____

Purpose:

Please specify completely: _____

Amount to be Paid:

Grade Slip	P_____
Registration Form	P_____
Certificate of Assessment	P_____
Certificate of Enrolment	P_____
Certificate of Grades	P_____
Checklist	P_____
Certified Document/s	P_____
Others	P_____
Total:	**P_____**
OR No.:	_____

This is to certify that I received the following document/s:

_____
(Signature over printed name and date received)

Assist by: _____

Date Received : _____

Approved by: _____
Registrar

***If credentials will be claimed by a person authorized by the student, he/she needs to bring the following upon claiming requested credentials:**
- Letter of consent signed by the student.
- Photocopy of Valid ID of the student and authorized person with signature & picture,

***CANCELLATION is Non-refundable.**
***Failure to claim the requested document/s after one month is automatically invalidated and needs to be requested again.**

FM-LPU-SC-REGO 23
Revision: 09
Effective: August 1, 2019

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