



DONALD AND BARBARA
ZUCKER SCHOOL of MEDICINE
AT HOFSTRA/NORTHWELL

Student Academic Record Request Form

Office of Student Records
Hofstra Northwell School of Medicine
500 Hofstra University
Hempstead, NY 11549-5000
somregistrar@hofstra.edu

Instructions: In order for the Office of Student Records to allow release of a student's academic record, you must complete this form. In accordance with FERPA, this request will only be granted if this request is deemed legitimate in nature.

Please complete the information requested on this form and return to the Office of Student Records at SOMregistrar@hofstra.edu.

Section I: Faculty Information

Faculty Name: _____

Faculty HofID: _____

Section II: Student Information

Student Name: _____

Student HofID: _____

Section III: Reason for the Request

Please provide a brief statement as to why you are requesting this student's academic record.

Section IV: (Office of Student Records Use ONLY) Request Granted/Denied

The Office of Student Records has granted/denied _____ access to the academic record of
(faculty member)

(student name)

Signature

Date