



**LPU- ST. CABRINI SCHOOL OF HEALTH SCIENCES, INC.**

(Formerly LPU-St. Cabrini College of Allied Medicine, Inc.)

Km. 54 National Highway, Makiling, Calamba City, Laguna

**OFFICE OF THE REGISTRAR**

Tel No. (049) 502-0975

**REQUEST FORM - TOR / DIPLOMA / OTHER CREDENTIALS  
(GRADUATE & TRANSFERRED-OUT)**

Name of Student \_\_\_\_\_ Student Number \_\_\_\_\_  
(Last Name) (First Name) (Middle Name)

Course / Program: \_\_\_\_\_ Contact No. \_\_\_\_\_  
Last Term of Attendance (for transferred out only): \_\_\_\_\_

Date Graduated (for graduate only): \_\_\_\_\_

**Please check requested document/s:**

- Transcript of Records
- Diploma
- Transfer Credential / Honorable Dismissal
- True Copy of Grades
- Certificate of Graduation
- Certificate of Units Earned
- Certificate for Medium of Instruction
- CAV Endorsement Letter
- Others / Please specify: \_\_\_\_\_

**Purpose:**

- Employment
- Board Examination
- Transfer to other school
- For Further Studies
- Graduate School
- 2nd Degree/Program

**Reason:**

- Financial Problem
- Health Condition
- Quality of Education
- Change of Residence
- Others: \_\_\_\_\_

Assist by \_\_\_\_\_ Date Received: \_\_\_\_\_

Approved by \_\_\_\_\_ Date Released: \_\_\_\_\_

**Registrar**

**CLEARANCE:**

- 1. OSAS \_\_\_\_\_
- 2. Library \_\_\_\_\_
- 3. Research \_\_\_\_\_
- 4. Palaestra \_\_\_\_\_
- 5. Accounting \_\_\_\_\_
- 6. Dean \_\_\_\_\_

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

(Signature and Date Received)

- Transcript of Records \_\_\_\_\_
- Diploma \_\_\_\_\_
- Transfer Credential / Honorable Dismissal \_\_\_\_\_
- True Copy of Grades \_\_\_\_\_
- Certification/s \_\_\_\_\_
- CAV Endorsement Letter \_\_\_\_\_
- Others \_\_\_\_\_

**Amount to be Paid:**

- Grad Fee: P \_\_\_\_\_
- Alumni: P \_\_\_\_\_
- Diploma: P \_\_\_\_\_
- TOR: P \_\_\_\_\_
- TCG: P \_\_\_\_\_
- Certification: P \_\_\_\_\_
- CAV: P \_\_\_\_\_

**Total: P \_\_\_\_\_ OR No.: \_\_\_\_\_**

FM-LPU-SC-REGO 24  
Revision: 10  
Effective: August 1, 2019



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**CLAIM STUB**

Name: \_\_\_\_\_

Course: \_\_\_\_\_

Date: \_\_\_\_\_

Student No.: \_\_\_\_\_

**Requested Document/s:**

- Transcript of Records
- True Copy of Grades
- Transfer Credential / Honorable Dismissal
- Diploma
- Certificate of Units Earned
- CAV Endorsement Letter
- Certificate of Graduation
- Certificate for Medium of Instruction
- Others, Pls. Specify: \_\_\_\_\_

Credential/s will be released on \_\_\_\_\_.

**NOTE:**

**\*If credentials will be claimed by a person authorized by the student, he/she needs to bring the following upon claiming requested credentials:**

- Authorization Letter 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.**

\_\_\_\_\_  
College In-charge

\_\_\_\_\_  
Registrar

EMU-ST. CARRINI SCHOOL OF HEALTH SCIENCES, INC.

1000 University Blvd., Cavite City, Cavite  
Tel: 042-322-1111, 042-322-1112, 042-322-1113

OFFICE OF THE REGISTRAR

REQUEST FORM - REGISTRATION OF OTHER PROFESSIONALS

Form No. 100-100-100-100-100



Registration No. \_\_\_\_\_  
 Applicant's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Contact No.: \_\_\_\_\_

Professional Title: \_\_\_\_\_  
 Issuing Authority: \_\_\_\_\_  
 Date of Issuance: \_\_\_\_\_

Reason for Registration: \_\_\_\_\_  
 (e.g., to practice in the Philippines, to teach, etc.)

Signature of Applicant: \_\_\_\_\_  
 Date: \_\_\_\_\_

Signature of Registrar: \_\_\_\_\_  
 Date: \_\_\_\_\_

EMU-ST. CARRINI SCHOOL OF HEALTH SCIENCES, INC.  
 OFFICE OF THE REGISTRAR

Registration No. \_\_\_\_\_  
 Applicant's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Contact No.: \_\_\_\_\_

Professional Title: \_\_\_\_\_  
 Issuing Authority: \_\_\_\_\_  
 Date of Issuance: \_\_\_\_\_

Reason for Registration: \_\_\_\_\_  
 (e.g., to practice in the Philippines, to teach, etc.)

Signature of Applicant: \_\_\_\_\_  
 Date: \_\_\_\_\_

Signature of Registrar: \_\_\_\_\_  
 Date: \_\_\_\_\_