SOS Students
SUFFOLK ONE SOURCE

Office of the Registrar

Academic Audit Request

Please print all information clearly.

Date: _____ Suffolk University Student ID# _____

Name: _____
Last *First* *Middle Initial*

Suffolk E-Mail Address: _____
Audits are e-mailed to your Suffolk account

Daytime Telephone Number:_____ Anticipated Graduation Date: _____

Degree: ☐ BA ☐ BS ☐ BSBA ☐ BSE ☐ BSJ ☐ BFA Major/Program: _____

Major Track:_____ Minor: _____

Concentration:_____ *(graduate students only)*

Additional Comments:

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Please allow 3-4 business days to process your request

Student Signature (required):_____Date: _____

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