UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

DUPLICATE DIPLOMA REQUEST FORM

Today's Date: _____

Your name as it appears on diploma: _____
Diploma will only be ordered with your enrolled name

.

Last Four Social Security Number: _____ Date of Birth: _____

Degree: _____

Graduation Date: _____

Home address to mail the diploma _____
Must be a street address no P.O. Box allowed

_____
City/State/Zip

Day Phone Number: _____

E-Mail address: _____

PAYMENT: _____ # of copies Medical ** @ $15.00 each

Total Amount Paid $_____

We only accept Check or Money Order only (*Make payable to the University of Miami Miller School of Medicine)*

SIGNATURE REQUIRED _____/_____/_____
Signature of Graduate *Date*

MAIL THIS FORM TO: University of Miami Miller School of Medicine
Office of the Registrar – RMSB Room 2100
P.O. Box 016960 (R128)
Miami, FL 33101

**Note: Diplomas are customarily ordered once a week, and should be received in approximately 14 days after they are ordered