THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER AT HOUSTON

Office of the Registrar
P.O. Box 20036 - UCT 2250
Houston, TX 77225
(713)500-3361 Fax: (713)500-3356

Application for Degree - MD/DDS

For MD or DDS programs only. Do not use this form if you are an Academic student.

Your diploma will be ordered from this form. You will be responsible for additional charges for corrected diplomas if you do not graduate as scheduled. Please type or print with black ink.

Date of Graduation _____

If you will complete the requirements for your degree prior to your schools commencement ceremonies, enter the date of the commencement ceremonies here. Otherwise, enter the last day of the month in which you will complete your degree requirements.

A									

Student ID

_____
Name (Last, First Middle)

1. School: ☐ DB ☐ Med

2. Candidate for Degree of: ☐ Doctor of Dental Surgery
☐ Doctor of Medicine

3. PRINT your name as it should appear on your diploma:

NOTE: Name will <u>appear</u> on diploma as indicated on <u>student-records</u>, unless legal documentaion is provided for name change.

_____ _____ _____ _____
First Name Middle Name Last Name Suffix

Note: If you have questions regarding how your diploma name may be styled, see Registrar's Office web site at *http://registrar.uth.tmc.edu/Services/diploma_name.html*

4. Address where mail will ALWAYS reach you (if your diploma must be mailed):

_____
Street Address

_____ _____ _____
City State Zip

_____ _____
Signature Date (mm/dd/yyyy)

Return completed form to: Office of the Registrar, UCT 2250

0199626261

Reset