REQUEST FOR DUPLICATE CERTIFICATE

Full Name of Person Requesting Duplicate Certificate:

_____
Last First Middle

Home Address_____
_____

Telephone No._____
(area code)

Business Address _____
_____

Telephone No. _____
(area code)

Type Of Certificate Requested: (Ex: Magna Cum Laude, Orthodontics)
_____

Dates of Attendance:
From:_____To:_____

Name to Appear on Certificate (PLEASE PRINT EXACTLY as you want it to appear, including DDS/DMD, if applicable)

_____

Billing Name and Address: ($30.00 + postage & handling)
_____
_____
_____

Return or FAX this form to:

Office of Academic Affairs
Room 4-A-11
University of Maryland, Dental School
666 W. Baltimore Street
Baltimore, Maryland 21201
FAX # 410-706-0406
Tel #: 410-706-7483
E-MAIL: tpate@umaryland.edu
or lmiller@umaryland.edu