REPLACEMENT DIPLOMA ORDER

NAME OF GRADUATE: _____

CURRENT ADDRESS: _____

_____

PHONE: _____

DATE OF GRADUATION: _____

PLEASE STATE REASON FOR REQUESTING REPLACEMENT DIPLOMA:

_____ Date _____
Signature of Graduate

Subscribed and sworn to before me this _____day of _____, _____.

City/County of _____ State of _____

_____Date _____
Signature of Notary Public

My Commission Expires _____

FEE FOR REPLACEMENT DIPLOMA: $75.00 (make check payable to MCW). Diploma will be sent certified mail in approximately 6 - 8 weeks. The diploma will be stamped "duplicate diploma". Please mail this notarized form plus the fee to:

THE OFFICE OF THE REGISTRAR
MEDICAL COLLEGE OF WISCONSIN
8701 WATERTOWN PLANK ROAD
MILWAUKEE, WISCONSIN 53226
(414)456-8733

Requests for graduates prior to 1970 must be directed to the Office of the Registrar, Marquette University, P.O. Box 1881, Milwaukee, Wisconsin 53201. Phone: (414) 288-1773.