



REPLACEMENT/ADDITIONAL DIPLOMA REQUEST

FULL NAME WHILE ATTENDING EASTERN VIRGINIA MEDICAL SCHOOL:

Last First Middle or Maiden

Full name to appear on replacement diploma (inclusive of accent mark, spaces, capitalizations, etc.)

NAME: _____
First Middle or Maiden Last

DATES OF ATTENDANCE: _____ GRADUATED: _____
From Year To Year MM/DD/YYYY

PROGRAM _____ SSN: _____ DATE OF BIRTH: _____
MM/DD/YYYY

Address to which the replacement diploma will be sent

NAME: _____
First Middle or Maiden Last
ADDRESS: _____
Street
City State Zip

Your Current Information:

ADDRESS: _____
Street
City State Zip
EMAIL: _____ Phone: ()

SIGNATURE: _____ DATE: _____
MM/DD/YYYY

COST: \$35.00 per replacement/duplicate diploma requested - (check or money order made payable to Eastern Virginia Medical School)

Request & payments must be sent to:
Eastern Virginia Medical School
Office of the Registrar
700 W. Olney Road
Norfolk, Virginia 23507