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.

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 appear on diploma as indicated on student-records, unless legal documentation 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

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Reset