Medical College of Wisconsin
GRADUATE SCHOOL OF BIOMEDICAL SCIENCES

REPLACEMENT DIPLOMA ORDER

NAME OF GRADUATE: _____

CURRENT ADDRESS: _____

_____

TELEPHONE: _____

DATE OF GRADUATION: _____

PLEASE READ ON FOR REQUESTING A REPLACEMENT DIPLOMA:

_____ Date _____

Signature of Graduate

Email: _____

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 GRADUATE SCHOOL OF BIOMEDICAL SCIENCES
MEDICAL COLLEGE OF WISCONSIN
8701 WATERTOWN PLANK ROAD
MILWAUKEE, WISCONSIN 53226
414-955-8218
gradschool@mcw.edu

(Revised 2010)