

**REPLACEMENT DIPLOMA ORDER**

**NAME OF GRADUATE:** \_\_\_\_\_

**CURRENT ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**PHONE:** \_\_\_\_\_

**DATE OF GRADUATION:** \_\_\_\_\_

**PLEASE STATE REASON FOR REQUESTING REPLACEMENT DIPLOMA:**

\_\_\_\_\_  
Signature of Graduate Date \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

City/County of \_\_\_\_\_ State of \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public Date \_\_\_\_\_

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.*