University of North Texas Health Science Center
Office of the Registrar, EAD 244
3500 Camp Bowie Blvd.
Fort Worth, TX 76107-2699
(817) 735-2201 / Fax (817) 735-0448
registrar@unthsc.edu

Diploma Request

Replacement Diploma & Official Copies of Diploma

A check or money order made payable to UNTHSC must accompany this order (excluding one-time fee for diploma copy)**.**

NOTE: Duplicate/Replacement diplomas will bear the signature of the current university officials.

Questions regarding data collected may be directed to the Registrar. (HB 1922)

Student ID OR Social Security Number			**Program** ☐ **Texas College of Osteopathic Medicine** ☐ **Graduate School of Biomedical Sciences** ☐ **School of Public Health** ☐ **School of Health Professions (PA & DPT)** ☐ **System College of Pharmacy**
Last Name	First Name	Middle Name	
Date of Birth	Daytime Telephone Number		
Other Names Used While Enrolled at UNTHSC			Graduating Year

Request

Duplicate/Replacement Diploma

Duplicate of diploma issued after graduation. Only available via mail or pick up in person. Diplomas will be printed with the name on file with the university. Please complete a change of name form if necessary.

☐ **Doctoral Diploma** ($50)

☐ **Masters Diploma** ($40)

☐ **Certificate** ($25)

Official Diploma Copy

Copy of diploma printed on plain white 8.5 x 11 paper. Official copies include seal, certification, and registrar's signature and are only available via mail or pick up in person. Unofficial copies can be emailed or faxed.

☐ **Official Diploma Copy** ($15 one-time fee. Contact us to find out if you have paid this fee.)

Number of copies:_____

Delivery Method:

☐ I would like to pick up my documents **in person**.
(*Please bring a photo ID to the front desk of Student Affairs for document pick up.)*

☐ **Mail** to: _____

_____

_____

_____

_____

☐ I would like to pick up my documents **at the graduation ceremony** if available or with the university provided copy of my diploma.

☐ **Fax** to:

Attn:_____

Fax Number: _____

☐ **Email** to:

_____

I certify that I am the person whose name appears on the name line of this form, and do hereby authorize release of my academic records via the method listed above.

_____ _____

Signature **Date**

Requests may take up to five days to complete.

For Office Use Only

Date Request Completed_____

Paid_____ **check #**_____ **($25 returned check fee)**