



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: \$52.00 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