Application for Graduation

College of Health Professions

University of Arkansas for Medical Sciences
4301 West Markham, Mail Slot 619
Little Rock, Arkansas 72205

Please print your name as you want it to appear on your diploma - LEGAL NAME ONLY

_____

FIRST MIDDLE LAST

Program from which I plan to graduate _____

When do you expect to graduate _____

Diploma Expected (Check One) Certificate_____ Asssociate _____ Baccalaureate _____ Masters _____ Doctorate _____

NOTE: If you are participating in the May graduation ceremony, we must have your height, weight and gender blanks completed (there is no ceremony in August and December).

_____ I will be attending graduation: Measurements for the gown are:

Height _____ Weight _____

Gender: Male _____
Female _____

OR

_____ I will not be attending the graduation ceremony. Please mail my diploma to the address below:

Name _____

Address _____

_____

Daytime Telephone Number _____

I understand that certificates and degrees are granted and diplomas delivered only after completion of all program requirements for graduation and the University clearance procedures. Accordingly, I understand that participation in the May UAMS Commencement exercises is for ceremonial purposes and does not guarantee granting of a certificate or degree.

SIGNED _____ DATE _____

The form is not valid without your signature and date