



**School of Medicine
Office of Graduate Studies
Diploma Request Form**

Full Legal Name: _____

_____ Last (Family) Name

_____ First

_____ Middle

Social Security Number: _____

E-Mail: _____

Address where diploma should be mailed.

_____ Number & Street

_____ City

_____ State

_____ Zip

Degree Received

- Doctor of Philosophy
- Master of Science
- Master of Science in Biomedical Informatics
- Master of Biomedical Informatics
- Master of Public Health
- Master of Physician Assistant Studies
- Master of Clinical Research
- Master of Clinical Nutrition
- Other _____

Graduate's Name (please print)

Graduate's Signature

Date

PLEASE MAIL TO

Registrar's Office L-109

Oregon Health & Science University

3181 SW Sam Jackson Park Rd.

Portland, OR 97239

OR FAX

Fax: 503-494-4629

Phone: 503-494-7800 or 800-775-5460

Office Hours: Monday through Friday 7:30am-4:00pm

Office Location: Mackenzie Hall Room 1120