

UCI School of Medicine

Office of Graduate Medical Education

CERTIFICATE REPLACEMENT REQUEST FORM

Date: _____
Requested by: _____
Maiden Name (if applicable): _____
Contact Number: _____
Email Address: _____

Training Program(s) Completed at UC Irvine:

| | | |
|-------|--------------|---------------------------|
| _____ | Dates: _____ | Certificate Request _____ |
| _____ | Dates: _____ | Certificate Request _____ |
| _____ | Dates: _____ | Certificate Request _____ |

Attestation

By signing this form, I confirm that I completed training at UC Irvine in the program(s) listed above during the dates provided. I am requesting a replacement copy of my training completion certificate(s). I understand that there is a \$50 processing fee, per certificate, associated with this request.

Print Legal Name of Authorizing Physician: _____

Signature of Authorizing Physician: _____

Date: _____

State of _____

County of _____

Your signature must be acknowledged before a Notary Republic.

Notary Section

On this ____ day of _____, 20__, before me personally appeared _____ to me known to be the person described in and who executed the foregoing instrument and acknowledged the s/he executed the same as his/her free and voluntary act and deed.

Print Name: _____

Notary Public, State of _____

(Seal)

My commission expires: _____

This document is good for one year from the last date of signature.