UC IRVINE 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.