



Application for Graduation

Students are to use this form to apply to receive the MD degree (diploma and transcript). Please type or print legibly.

NAME: _____

STUDENT ID #: _____

MAILING ADDRESS: _____

PHONE: _____ **E – MAIL:** _____

Please check appropriate boxes:

I have fulfilled the following graduation requirements:

Office Notes:

- | | |
|--|--------------------------|
| <input type="checkbox"/> Successful completion of Basic Sciences | <input type="checkbox"/> |
| <input type="checkbox"/> Pass USMLE Step 1 and send score report directly to the school | <input type="checkbox"/> |
| <input type="checkbox"/> Complete required number of weeks of rotations (<i>cores and electives</i>) | <input type="checkbox"/> |
| <input type="checkbox"/> Pass USMLE Step 2 CK and send score report directly to the school | <input type="checkbox"/> |
| <input type="checkbox"/> Pass USMLE Step 2 CS and send score report directly to the school | <input type="checkbox"/> |
| <input type="checkbox"/> Complete graduation paper (<i>must be approved by SJSM Board</i>) | <input type="checkbox"/> |
| <input type="checkbox"/> In good academic standing | <input type="checkbox"/> |
| <input type="checkbox"/> Clear all financial obligations for tuition and other charges | <input type="checkbox"/> |

Finalization of the diploma is subject to successful completion of all the above requirements

Please note that failure to fulfill any of the above requirements will deem the student ineligible for graduation.

Please send my diploma to

- My mailing address above
- Different address: _____
- In office pick up

Student Signature: _____ Date: _____

FOR OFFICE USE ONLY

Department Approval Signatures:

Finance: _____

Date: _____

Financial aid: _____

Date: _____

Clinical Services: _____

Date: _____

Registrar's Office: _____

Date: _____