

Current Name: \_\_\_\_\_

Name to be printed on diploma: \_\_\_\_\_

\*\*\*Must be the same name under which you attended or official documentation supporting a name change must be included (court documents for legal name change) \*\*\*

Date of Birth:

SSN:

Degree Awarded:

Date Degree Awarded:

Diploma Mailing Address/Contact Information:

Phone:

Email:

Street Address:

City:

State:

Zip:

Signature of student: (For security reason, all requests must be signed by the graduate)

Please enclose a check for \$45 made payable to WFSM and mail with completed form to:

Enrollment Services  
Wake Forest School of Medicine  
Medical Center Boulevard  
Winston-Salem, NC 27157

\*\*Please do not return this form via email. Email is not a secure transmission of data.\*\*