



XAVIER UNIVERSITY
X U S O M
SCHOOL OF MEDICINE

GRADUATION/ DIPLOMA APPLICATION
Doctor of Medicine

1000 Woodbury Road Suite 109
Woodbury, NY 11797
Phone: (516) 333-2224 Email: registrar@xusom.com
Fax: (516) 921-1070

(A) PERSONAL INFORMATION

Please print clearly and provide **ALL** the information below. Print your name **EXACTLY** as you wish it to appear on your diploma.

① Title: Mr. / Ms.	② Name: (Last, First, M.I.):	③ Social Security/ Insurance number:	④ Date of Birth:
⑤ Local Address: (Current information)		⑥ Permanent Address: (Post-graduation)	
⑦ Local/Mobile Phone No.: ()		⑧ Permanent Phone No.: ()	⑨ E-mail:

(B) DEGREE INFORMATION

① Graduation Date: Day: ____ Month: ____ Year: ____	② Attendance with Xavier University School of Medicine : Month: ____ Year: ____ to Month: ____ Year: ____
③ Convocation Date: Year: ____	④ HONORS (Office use only):

(C) PREVIOUS DEGREE INFORMATION (List all previous degrees)

① _____ Degree Date School	② _____ Degree Date School
③ _____ Degree Date School	④ _____ Degree Date School

IMPORTANT INFORMATION:

You will receive notification of your graduation application **prior** to the date of commencement. **All** students must be financially and academically cleared to participate. (Please mail or fax this form to the address above.)

I certify that information above is correct and have satisfied all requirements for the Degree Doctor of Medicine.

Student's Signature: _____ Date: _____

OFFICE USE ONLY

Dean:	Accounting:	Registrar:
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