College of Health Sciences
Certificate Approval

FOR OFFICE USE	FOR OFFICE USE

INSTRUCTIONS

A) Print all information legibly.

B) This form is due to the Office of the Register no later than the last week of the quarter in which the requirements for the certificate are completed.

C) When completed, return this form to:
Office of the Registrar
600 S. Paulina St., Suite 440
Chicago, IL 60612
or
fax to (312) 942-2310

QUARTER/YEAR OF COMPLETION

Indicate **Quarter & Year** in which degree requirements will be completed:

☐ SUMMER (Aug)

☐ FALL (Dec) YEAR: **201** _____

☐ WINTER (March)

☐ SPRING (June)

INDICATE SPECIALTY

☐ Healthcare Ethics
☐ Specialist in Blood Bank
☐ Specialist in Blood Bank *(traditional program)*
☐ Specialist in Blood Bank *(professional program)*

NAME FOR CERTIFICATE

PRINT name exactly as it is to be printed on certificate.
(Name only, No degree abbreviations.)

First _____

Middle _____

Last _____

RUCONNECTED ID# _____

LAST Name _____

FIRST Name _____

Address _____

City _____

State _____ Zip _____

Phone (Day or message) _____

Personal E-mail _____

ALL STUDENTS MUST COMPLETE MAILING INFORMATION

#1 ☐ Send my certificate to same name and address as above.

#2 ☐ Send my certificate to another address as indicated below.

Address _____

City _____

State _____ Zip _____

REQUIRED SIGNATURES

STUDENT'S SIGNATURE & DATE:

PROGRAM DIRECTOR'S SIGNATURE & DATE:

FOR OFFICE USE ONLY

Certificate Ordering and Distribution Information

Ordered:	Reordered: Why:	
Received:	Received:	

☐ Student picked up certificate Picked up by: _____ Date: _____

☐ Certificate mailed: _____ Transcript updated on: _____

☐ Returned by Post Office: _____
Why:

02/10