



# College of Health Sciences Certificate Approval

FOR OFFICE USE	FOR OFFICE USE
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### INSTRUCTIONS

- A)** Print all information legibly.
- B)** This form is due to the Office of the Registrar 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: 200 \_\_\_\_\_
- WINTER (March)
- SPRING (June)

### INDICATE SPECIALTY

- Healthcare Ethics
- 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: \_\_\_\_\_