



UNIVERSITY OF MARYLAND, COLLEGE PARK
The Office of the Registrar



CERTIFICATION OF PROFESSIONAL PRACTICE DEGREE

Date: _____

Print Full Name (Last, First, Middle)

Student University ID Number (UID)

Address

Graduate Program

City, State, ZIP

Degree Sought:

(Area Code) Telephone

Email Address

The student named above is a candidate for the _____ degree, and who seeks the degree at the _____ (semester/year) Commencement. This candidate has met all the requirements of the graduate program including (if applicable):

Capstone Research Project	Date Completed

Comprehensive

Examinations passed: Yes ☐ No ☐ **Date Passed** _____

Provisions have been met. Yes ☐ No ☐

Advisor (Print Name then Sign)

Date

Telephone extension and Email Address

Director of Graduate Program (Print Name then Sign)

Date

Telephone extension and Email Address

Please return this form to:

Please submit this form electronically to registrar-graduate@umd.edu
or mail to the Office of the Registrar, 1113 Mitchell Building, College Park, MD 20742-5121