UNIVERSITY OF MARYLAND, COLLEGE PARK
The Office of the Registrar

CERTIFICATION OF DOCTOR OF AUDIOLOGY DEGREE

Date: _____

			—			—				

_____ Student ID Number
Print Full Name (Last, First, Middle)

C	A	U	D

_____ Graduate Program
Address

_____ Degree Sought:
_____

_____ City, State, ZIP

_____ _____ Email
Address
(Area Code) Telephone

The student named above is a candidate for the Doctor of Audiology (Au.D.) 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:

The Office of the Registrar
1113 Mitchell Building • University of Maryland
College Park, Maryland 20742-5121
301.314.9568 FAX