UNIVERSITY OF MARYLAND, COLLEGE PARK
The Office of the Registrar

CERTIFICATION OF DOCTOR OF AUDIOLOGY DEGREE

Date: _____

Student University ID Number (UID)

_____
Print Full Name (Last, First, Middle)

C	A	U	D

Graduate Program

_____
Address

_____
City, State, ZIP

Degree Sought: _____

_____
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:

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

Revised 05/2022