



UNIVERSITY OF MARYLAND, COLLEGE PARK
The Office of the Registrar



CERTIFICATION OF DOCTOR OF AUDIOLOGY DEGREE

Date: \_\_\_\_\_

Print Full Name (Last, First, Middle)

Student University ID Number (UID)

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):

Table with 2 columns: 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