HOWARD UNIVERSITY
Medical Diploma Translation Request Form

*The name that appears on the **original** diploma will be printed on the replacement diploma.*

Last Name **(As appears on the original diploma)** First Name Middle Name

Address

City State Country Zip

Phone: _____

E-Mail Address: _____

Howard Student I.D. Number or SSN: _____

Date of Graduation: _____
Day Month Year

Degree Received: _____

_____ _____
Signature Date

This request form will not be processed until ALL portions are completed.

Please feel free to direct any questions to:

College of Medicine
Office of Academic Affairs
c/o Darlene Wall
520 W. Street, NW, Rm. 527
Washington, DC 20059
E-Mail Address: dmwall@howard.edu
Phone Number: 202-806-9491
Fax Number: 202-806-7934