

Medical University of South Carolina
Request for Replacement Completion Certificate

Instructions:

1. Please complete the form below
2. Send form along with payment to the address below.
3. The information supplied will be sent to the current Program Director of your former residency program for signature/verification.
4. Allow 6-8 weeks for delivery

NAME: _____ **DATE:** _____

OTHER NAME KNOWN AS: _____ **BIRTH DATE:** _____

EMAIL ADDRESS: _____ **PHONE NUMBER:** _____

RETURN ADDRESS: _____

PROGRAM COMPLETED: _____

DATES OF ATTENDANCE: _____

NAME AS YOU WISH IT TO APPEAR ON THE CERTIFICATE: _____

REASON FOR REQUEST: _____

Please enclose a check made payable to "MUSC."

TOTAL CHARGE: \$45.00

I hereby certify that the above statements are true. I understand that the Medical University of South Carolina reserves the right to institute any appropriate legal or other proceedings for misrepresentation of the information stated above or in case of fraud.

SIGNATURE: _____ **DATE:** _____

PROGRAM DIRECTOR: _____ **DATE:** _____

RETURN TO: Beth Jones

Medical University of South Carolina, Office of Graduate Medical Education

169 Ashley Avenue, Room 202 Main Hospital, MSC333, Charleston, SC 29425

Phone: 843-792-2575

Fax: 843-792-9295

E-mail: joneseli@musc.edu