



**GRADUATE MEDICAL EDUCATION  
CERTIFICATE RE-ORDER FORM**

Office of the Registrar  
Mail Stop 4029, 3901 Rainbow Boulevard  
Kansas City, KS 66160-7191  
PHONE: 913-588-1048 FAX: 913-588-4697

**Print Name** \_\_\_\_\_

Student ID: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB: \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Mailing Address  
\_\_\_\_\_  
\_\_\_\_\_

**Print Official Name** for Certificate

\_\_\_\_\_  
First Middle Last Name Title

\*To change your name we need two forms of ID attached to the request. Documentation may include a copy of the following: current driver's license, marriage license, court order, or social security card.

Please indicate what type(s) of certificate(s) you would like to order:

	Program	Year Received
<input type="checkbox"/> Residency <input type="checkbox"/> Fellowship		
<input type="checkbox"/> Residency <input type="checkbox"/> Fellowship		
<input type="checkbox"/> Residency <input type="checkbox"/> Fellowship		
Total Number of Certificates Ordered:		

Mailing Options	1 Certificate	2 Certificates	3 Certificates
Pickup in 3001 Student Center	<input type="checkbox"/> \$10	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30
Domestic Mail	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40
Certified Domestic Mail	<input type="checkbox"/> \$25	<input type="checkbox"/> \$35	<input type="checkbox"/> \$45
Certified International Mail	<input type="checkbox"/> \$35	<input type="checkbox"/> \$45	<input type="checkbox"/> \$55

**Payment Options**

Check or Money Order  Visa  MasterCard

Credit Card Number \_\_\_\_\_

Security Code \_\_\_ \_\_\_ \_\_\_ Expiration Date \_\_\_ \_\_\_ / \_\_\_ \_\_\_

Name on Card \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Office Use Only  
Date Received: \_\_\_\_\_ Time Received: \_\_\_\_\_ By: \_\_\_\_\_  
Payment Processed: \_\_\_\_\_