GRADUATE MEDICAL EDUCATION CERTIFICATE RE-ORDER FORM

Name on Certificate _____ DOB: _____

Phone # (____) _____ Email Address _____

Mailing Address

_____

_____

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

	Program	**Year Received**
☐ Residency ☐ Fellowship		

1 Certificate	**2 Certificates**	**3 Certificates**
☐ $25	☐ $35	☐ $45

Payment – Please submit check payment with request form to:

WCGME Office, 1010 N Kansas, Wichita, KS 67214-3199

PHONE: 316-293-2665 FAX: 316-293-1893

Signature _____ Date _____

Please allow 5 – 10 business days for processing.

Office Use Only

Date Received: _____ Time Received: _____ By: _____

Payment Processed: _____