School of Medicine
Intent to Graduate Form

PLEASE FAX TO 1-800-565-7177 or 407-488-1743, Attn: Registrar's Department

PRINT name, including middle name: **NOTE: If name indicated does not exactly match ECFMG records, you will be required to submit a signed passport showing your full and legal name.**

__Mr.__Mrs.__Ms. _____
(Name printed on diploma)

Student I.D. Number: _____ **No P.O. BOX Addresses**

Address (To which diploma can be shipped) _____

City _____ State _____ Zip _____ Country _____

Phone# _____ Cell# _____

Email Address _____

Term in which you anticipate graduating:

Spring (April/May) 20___ Summer (August) 20___ Fall (December) 20___

☐ **I authorize SMU to submit my official final transcript to ECFMG following graduation.**
(Transcript will be submitted upon confirmation that there is no outstanding balance on my account.)

Student's Signature _____ Date _____

The $500.00 Graduation Fee is required for all graduates.
Students will be billed by Student Accounts upon receipt of this form.

PLEASE COMPLETE THE FOLLOWING INFORMATION, IF AVAILABLE:

Board Scores: STEP 1 _____ STEP 2CK _____ Step 2CS _____
Residency Information: Hospital: _____ Contact: _____
Address: _____ City _____ State ____ Zip ____
Specialty: _____ Phone: _____
May students contact you via email in regard to your experiences? Yes ___ No ___
Comments: _____

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To Be Completed By SMU

Accounting Office:
Accountings Signature: _____ Date: _____
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Admissions Office:
Admissions Office Signature: _____ Date: _____
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Clinical Sciences Office:
Clinical Sciences Office Signature: _____ Date: _____
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Registrars Office:
Registrar Office Signature: _____ Date: _____
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REV. 2/2012