Application for DMM Certificate

Student ID #: ________________________

Student Name: (print as you want it to appear on your certificate)

____

First *Middle* *Last*

Mailing Address: ____

____

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City *State* *Zip*

Student Email: ____________________________ **Student Phone:** ____________________

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Student's Signature *Date*

- -

To be filled out by the program director:

Certificate Completion Term: *(year)* **FLGR** _____ **WNGR** _____ **SPGR** _____ **SMGR** ______

Courses Completed for Certificate: (check as completed and show the term for completion and fill in the elective

- ☐ **DMM-611 Principles of Disaster Medicine and Management**
- ☐ **DMM-647 Disaster Emergency Planning**
- ☐ **DMM -** _________________________________ (elective)

____ _____________________

Program Director's Signature *Date*

____

Date Received in Registrar's Office

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Date Processed by Registrar's Office

Distribution: Advisor file, Student, Cert. Officer, Office of the University Registrar