

OFFICE OF RECORDS AND REGISTRATION
St. Cloud State University
720 4th Avenue South
St. Cloud MN 56301-4498

REQUEST FOR DUPLICATE DIPLOMA

SSN or SCSU I.D. # _____ Date _____

Complete name as shown on University records.

First Middle Maiden Last

Print your name below as you wish it to appear on the diploma. **DO NOT** use nicknames or change the spelling of your legal name. You may use a middle initial or delete your middle name or elect to include or delete a maiden name.

First Middle Maiden Last

Degree Earned (Please check one)

- | | |
|--------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Associate in Arts | <input type="checkbox"/> Bachelor of Music |
| <input type="checkbox"/> Associate in Elective Studies | <input type="checkbox"/> Bachelor of Science |
| <input type="checkbox"/> Associate in Science | <input type="checkbox"/> Master of Arts |
| <input type="checkbox"/> Bachelor of Applied Science | <input type="checkbox"/> Master of Business Administration |
| <input type="checkbox"/> Bachelor of Arts | <input type="checkbox"/> Master of Science |
| <input type="checkbox"/> Bachelor of Elective Studies | <input type="checkbox"/> Specialist |
| <input type="checkbox"/> Bachelor of Fine Arts | |

Date of Graduation _____

Mail diploma to: Name _____
Street Address _____
City, State, Zip _____

Enclose check or money order for required \$10 fee.

Please allow approximately three weeks for receipt of diploma.