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 (\$10 fee applies)**

(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. 4/2019