

UNIVERSITY OF CALIFORNIA, IRVINE

UNIVERSITY EXTENSION

REQUEST FOR DUPLICATE CERTIFICATE

Date: _____

Note: Please allow approximately 1-2 weeks for processing.

CERTIFICATE PROGRAM:

When was original Certificate issued: _____

Name: _____

(List name as you would like it to appear on your certificate)

Address: _____

City: _____

State: _____

Zip: _____

Phone: Day: _____

Evening: _____

Social Security or Student ID Number: _____

Payment must be included with request.

MY CHECK FOR \$35 IS ENCLOSED (Payable to Regents of University of California).

CHARGE TO: VISA MASTERCARD AMERICAN EXPRESS

ACCOUNT NUMBER: _____

EXP DATE: _____

AUTHORIZED SIGNATURE _____

Mail or Fax To:

UNIVERSITY OF CALIFORNIA, IRVINE
UNIVERSITY EXTENSION
PO Box 6050, IRVINE, CA 92616-6050
FAX (949) 824-2090