INSTITUTE OF COMMUNITY AND FAMILY HEALTH, INC. (ICFHI)

Graduate School for Public Health

4th Floor, Medical Arts Building, Fe del Mundo Medical Center
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Cellphone number: +639059454511 / Landline number: +63284206770

FORM 11.0 APPLICATION FOR GRADUATION

Date: _____

Name: _____

Diploma Name Information: PRINT the name exactly as you like PRINTED on the diploma
Note: ONLY variations of the OFFICIAL name of the record are allowed.

_____
PRINTED NAME

Eligibility for Graduation: A candidate must:

1. *Meet all academic requirements for MPH.*
2. *Pay the required graduation fee.*
3. *Clear all outstanding accounts with the school.*
4. *Apply by graduation application form through the registrar.*

TO BE FILLED UP BY THE SCHOOL OFFICIAL

Received by: _____ Date: _____
Printed Name and Signature
School Registrar

Graduation Fee Paid: _____ Fee paid previously during enrollment _____

_____Cash

_____Check Number: _____ Issuing Bank: _____ Date Issued: _____

❒ Approved ❒Disapproved

Date Degree Conferred: _____

DIPLOMA and TOR: Mailed: _____ Details: _____

Picked up by _____ Details: _____

Date sent: _____ Details: _____

Date Picked up: _____ Details: _____