**Office of Student &**

**Academic Services**

3500 Camp Bowie Blvd., EAD-716

Fort Worth, TX 76107

Phone: 817.735.2401

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sph@unthsc.edu

 **DEGREE CANDIDATE INFORMATION**

**PERSONAL INFORMATION**

**FIRST NAME** **LAST NAME**

**OTHER NAMES USED       STUDENT ID#**

**GRADUATION DATE**

**DEGREE SOUGHT       DEPARTMENT CONCENTRATION**

**TITLE OF THESIS/DISSERTATION**

**PRESENT MAILING ADDRESS:**

**STREET NUMBER & NAME**

**CITY       STATE       ZIP**

**PRIMARY PHONE       CELL PHONE       EMAILADDRESS**

**PHYSICAL ADDRESS WHERE YOU CAN BE REACHED IN THE NEXT 6 MONTHS (IF DIFFERENT FROM ABOVE)**

**STREET NUMBER & NAME**

**CITY       STATE       ZIP**

**PRIMARY PHONE       CELL PHONE       EMAILADDRESS**

***Please complete the following information for accreditation purposes. The Council on Education for Public Health (CEPH) requires that accredited Schools of Public Health collect employment and education information at the time of graduation. Thank you!***

**PLEASE PROVIDE EMPLOYMENT AND EDUCATIONAL INFORMATION:**

***IF YOU ARE EMPLOYED UPON GRADUATION, PLEASE PROVIDE THE FOLLOWING INFORMATION*:**

**NAME OF ORGANIZATION       TITLE OR POSITION**

**STREET NUMBER & NAME**

**CITY       STATE       ZIP**

**WORK PHONE**

***IF YOU ARE CONTINUING YOUR EDUCATION UPON GRADUATION, PLEASE PROVIDE THE FOLLOWING INFORMATION:***

***UNIVERSITY NAME*       *DEGREE SOUGHT***

***STREET NUMBER & NAME***

***CITY*       *STATE*       *ZIP***

***IF NEITHER OPTION ABOVE APPLIES TO YOU, CHECK THIS BOX:***

**PREVIOUS DEGREE(S) HELD:**

**SCHOOL       DEGREE**

**GRADUATION DATE       MAJOR**

**SCHOOL       DEGREE**

**GRADUATION DATE       MAJOR**