



REPLACEMENT DIPLOMA REQUEST

NAME _____

Please print **First** _____ **Middle** _____ **Last** _____
(name used will be the name listed in the student information system. If a new name is requested legal documentation is required)

ADDRESS _____

CURRENT PHONE NUMBER _____

SOCIAL SECURITY# _____ DATE OF BIRTH _____

DEGREE RECEIVED _____ MONTH/YEAR _____
DEGREE AWARDED _____

EMAIL ADDRESS _____

STUDENT'S SIGNATURE _____ DATE _____

(by signing this form permission is granted to process the request and verifies student's identity)

RETURN THIS FORM WITH PAYMENT TO: **LSUA**
Office of the Registrar
8100 Hwy 71 South
Alexandria, LA 71302

CREDIT CARD PAYMENT OPTION:
(2.75% will be added to all credit card transactions)

Name on Card _____

Credit Card Number _____ Expiration Date: _____

Zip Code of credit card _____

CVV card number _____ Card Holder Signature _____
(three digit number on the back of card)

FOR OFFICE USE ONLY

DEGREE VERIFIED BY _____

PAYMENT RECEIVED AND PROCESSED BY ACCT _____ DATE _____
NAME DATE

SENT TO ACADEMIC AFFAIRS FOR PROCESSING _____ DATE _____

DUPLICATE DIPLOMA MAILED TO STUDENT _____ DATE _____