AOMA
GRADUATE SCHOOL of INTEGRATIVE MEDICINE

First name:	Last:		Maiden:
Current Street Address:			
City, State, Zip:			
Telephone:		Email:	

Name to be printed on diploma:		
First:	Middle:	Last:

Delivery options, please check appropriate box below:

☐ Will pick up

☐ Mail now to home address listed above

Payment Information *This request must be accompanied with payment of $40 fee per diploma ordered.*

Card type: ☐ Discover ☐ MC ☐ Visa ☐ AE

Card number:	CVV number:
Cardholder:	Expiration Date:

Billing Address:

Zip:

I authorize the charge of $40 as the named cardholder.

Signature:	Date:

I certify that I am the person whose name appears on this form.

Signature:	Date:
Payment received by:	Date:
Request fulfilled by:	Date: