



ROYAL COLLEGE OF
PHYSICIANS OF IRELAND

DECLARATION FOR REPLACEMENT DIPLOMA

I _____ (Full Name Clearly Written)

do solemnly swear that my previous Diploma was destroyed.

Type of Diploma (i.e. Membership, Licentiate etc): _____

Date of Conferring: _____

Signed: _____

Date: _____ Phone: _____

Current Mailing Address: _____

E-mail: _____

Signed by Commissioner for Oaths: _____

Seal: _____

THE FEE FOR A REPLACEMENT DIPLOMA IS €60