Southeast HEALTH
College of Nursing & Health Sciences

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TRANSCRIPT REQUEST FORM

Please complete this form and return to the Registrar's Office.

_____
First Name *Middle* *Last* *Maiden/Previous Name*

_____
Attendance Date *Date of Birth (mm/dd/yyyy)* *Phone Number*

_____
Mailing Address *City* *ST* *Zip*

☐ **Send upon approval *(ALLOW THREE BUSINESS DAYS)***

☐ **Send after current term grades are available**

☐ **Send after graduation is posted.**

TRANSCRIPTS WILL ONLY BE PROCESSED IF:
a $5.00 FEE HAS BEEN RECEIVED
and
ALL OUTSTANDING DEBTS HAVE BEEN SATISFIED.

Please send my official transcript to:

_____
Name of School/Business/etc *Attention*

_____
Address *City* *ST* *Zip*

- **Federal law prohibits release of this transcript or its contents to any party without the written consent of the student.**
- **An official transcript is one mailed directly to the requested recipient from Southeast Missouri Hospital College of Nursing and Health Sciences.**
- **Transcripts from high schools or other colleges cannot be duplicated. You must contact them directly for transcripts.**

I hereby authorize the release of my transcript as indicated.

_____
Signature *Date*

For Office Use Only

Date Received _____ **Payment Received/Receipt #** _____

Approvals: ***Registrar*** _____ ***Business Manager*** **(account clear)** _____

Date Sent _____ **Processed By** _____

Revised: Sept 2016