

TRANSCRIPT REQUEST

Moses Cone Health System Radiologic Technology Program
1200 N. Elm Street
Greensboro, NC 27401-1020

FOR OFFICE USE ONLY
_____ Initials of Person Taking Request
_____ Amount / Type of Payment Received Cash Check Money Order (Payable to Moses Cone Health System)
_____ Date Requested
_____ Initials of Person Processing Request
_____ Date Mailed or Picked Up

PLEASE PRINT ALL THE INFORMATION ON THIS REQUEST

Social Security Number _____ / _____ / _____

Last Name	First	Middle/Maiden
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Address

City	State	Zip Code
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Name Used While Enrolled (if different from above) _____ Graduation Year _____

Contact Phone Number _____

In accordance with the Family Educational Rights and Privacy Act of 1974, I hereby grant permission to release a copy of my official transcript.

Signature _____ Date _____
(Mandatory For Release of Transcript)

Student/Graduate Instructions:

A separate transcript request must be completed for each transcript mailed to different persons or addresses. Any outstanding financial obligations to the program or Moses Cone Health System must be paid before a transcript may be issued. Official transcripts are \$5.00 per copy. **Transcript fee(s)** must be received before a transcript may be issued.

Mail or Pick-up:

_____ Pick up transcript (make an appointment to pick up and bring photo identification)
_____ Someone else to pick up transcript. If so, Who? _____
(person must have a photo I.D.)
_____ Mail

Print below: The Name, Title and Address of The Person or Institution Number of Copies _____
