ST. LOUIS COLLEGE OF HEALTH CAREERS

TRANSCRIPT REQUEST FORM

Request Date: ______________________ # of Transcripts Requested: __________________

Student's Name (at time of enrollment): ____

Social Security Number: _______ - _____ - _______ Date of Birth: __________________

Current Address: ____

____

Current Phone #: ____

Program: ____

Start Date: _________________________ Graduation Date: _________________________

NOTE: There is a $5.00 fee for each Transcript requested.

Transcripts cannot be issued unless all accounts with the College are paid in full. If the registrar is unavailable, the $5 fee will be applied towards your request and an official transcript will be sent. If you have an outstanding balance, the $5.00 will be applied towards your balance and the registrar will notify you of this.

This is my authorization to release my Official College Transcript(s) to the following institution(s):

Institution: ____

Address: ____

City/State/Zip Code: ____

ATTN: ____

Institution: ____

Address: ____

City/State/Zip Code: ____

ATTN: ____

Student Signature: ____

Please mail this Transcript Request Form to:

County Campus:
St. Louis College of Health Careers
1297 N. Hwy Dr.
Fenton, MO 63026
ATTN: Registrar
Fax: 636-489-2286

Metro Campus:
St. Louis College of Health Careers
909 S. Taylor Ave.
St. Louis, MO 63110
ATTN: Student Services
Fax: 314-652-4825