



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 (cash, credit card, or money orders accepted; no personal checks).

Transcripts cannot be issued unless all accounts with the College are paid in full. 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: 314-884-2836