TRANSCRIPT REQUEST

Transcript requests take approximately 3 business days to process. All financial obligations to the University must be met before a transcript is released. Transcripts will not be faxed or emailed. There is no charge for this service.

U__ __ -__ __-__ __ __ __ ________________________________________________________________________

ID Number   Last Name (include any former names)   First Name            Middle Name

________________________ _____________________________________________

Phone Number   Email Address

Dates of attendance: ____ /______ to ____ /______

Month / Year (MM/YYYY)   Month / Year (MM/YYYY)

Program:  □ Predoctoral    □ Postdoctoral

Area(s) of Specialization

Degree(s)/Certificate(s) Awarded, if any:

□ Doctor of Dental Medicine (D.M.D.)
□ Master of Science (M.S.)
□ Doctor of Science in Dentistry (D.Sc.D.)
□ Doctor of Philosophy (Ph.D.)

□ Certificate of Advanced Graduate Study (C.A.G.S.)
□ Master of Science in Dentistry (M.S.D.)
□ Doctor of Science (D.Sc.)
□ Fellowship/Internship

Number of transcripts to be picked up:           _________           Total number of transcripts to be mailed:         _________

(Phot ID required)

Signature (requests cannot be processed without a written signature)      Date

Mailing Addresses:

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