

_____ *last name*

_____ *first name*

_____ *graduation year*

TRANSCRIPT REQUEST FORM

LAKE ERIE COLLEGE OF OSTEOPATHIC MEDICINE

Office of the Registrar

1858 West Grandview Boulevard

Erie, PA 16509 (814) 866-6641

INSTRUCTIONS:

- (1) Complete legibly and carefully.
- (2) Use a ballpoint pen only.
- (3) List complete and correct address below.
- (4) **Complete one transcript request form for each transcript requested.**
- (5) **There is a \$5.00 transcript fee charged for each transcript.**

Today's Date: _____ Date You Want Transcript Mailed: _____

Student Name: _____ Telephone: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Student Social Security #: _____ Birth Date: _____

Dates of Attendance: _____ E-Mail Address: _____

SEND TRANSCRIPT TO:

Institution/Organization: _____

Attention: _____

Address: _____

City: _____ State: _____ Zip Code: _____

If you want Class Rank included, check here:

Transcript Requested for:

- Admission
- Internship/Residency
- Personal Information

- Employment
- Licensure
- Other

STUDENT'S SIGNATURE/RELEASE AUTHORIZATION

NOTE: Transcripts issued to students MUST be stamped "Student Copy." "OFFICIAL" transcripts needed for internships, residencies, employment or admission to another university, etc., can be released to students but will be sealed and marked "OFFICIAL TRANSCRIPT" on the back of the envelope.

REGISTRAR'S USE ONLY

DATE MAILED: _____	BY: _____
PAYMENT RECEIVED: _____	STATUS: _____