



## 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.**

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