



RECORDS (TRANSCRIPT) REQUEST FORM: Complete and return this form to the address below.

Date: _____ **Student ID Number or SS#** _____

Last Name	First Name	Middle Initial	Maiden Name
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Please List **All Last Names** that you may have used on records: _____

Street Address	City	State	Zip
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Home Phone	Cell Phone	Work Phone	E-mail Address
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Is this Street Address New: Yes No Birth Date: _____

Did your Graduate from St. Elizabeth: **YES** **NO** If **YES**, Month and Year: _____

If **NO**, Dates of Attendance _____ to _____

I request the following information be sent to myself the person(s) at the address(es) below.

Information to be sent (list specific records to be included): Official Transcript Recommendation

Because this information is protected by confidentiality rules, it must be sent to a specific person. **Copy costs of \$5.00 per transcript shall be charged.** Additional pages of record shall be charged at \$.35 per page. Charges must be paid prior to documents being sent. Make Checks payable to **ST. ELIZABETH SCHOOL OF NURSING**

Please Note: because this is protected confidential information, the School **WILL NOT FAX** any part of your requested record information to a Third Party.

Information is to be sent to:

Copy 1

Copy 2

Name

Name

College, Hospital or Receiving Agency

College, Hospital or Receiving Agency

Address

Address

City, State, Zip

City, State, Zip

For additional copies, please attach additional page(s) with name and address to whom copies are to be sent.

Signature

Date

Send This Request Form To:

**Registrar
St. Elizabeth School of Nursing
1508 Tippecanoe Street
Lafayette IN 47904-2198**

Office Use Only: Date Rec: _____	Fee: \$_____
Date Sent: _____	By: _____ Copy to File