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Transcript Request Form

All financial obligations and records held from the school must be met before an official transcript can be issued. Please complete and sign the request and return it in person, or by fax, email, or mail to the address above with the processing fees if applicable. Please allow up to 2 business days for processing.

Student Name: _____

Student SSN#: _____

Address for Transcripts: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

OFFICIAL TRANSCRIPTS REQUESTED OFFICIAL

First Request: No charge
transcript)

Additional Requests: (\$10 per

Additional Locations for Transcripts to be sent:

Address for Transcripts: _____

City: _____ State: _____ Zip: _____

Address for Transcripts: _____

City: _____ State: _____ Zip: _____

Address for Transcripts: _____

City: _____ State: _____ Zip: _____

If you have any questions regarding the request of academic transcripts, please contact the our office at (913) 703-5851. Please arrange to pay the required \$10 fee per transcript after the first transcript. Transcripts will be processed after both the form and the payment have been received. If payment is not received within 30 days of receipt of this form, the form will no longer be valid. Payment methods: 1. To pay via phone, call the Business Office. 2. To pay by mail or in person, include payment with this form. For security purposes, please do not mail cash. *I hereby authorize PREMIER HEALTH CARE ACADEMY & SCHOOL OF NURSING L.L.C. to release my transcripts according to the above selection.

Student Signature: _____