Arnot Ogden Medical Center School of Radiologic Technology 555 St. Joseph's Blvd. Elmira, NY 14901 (607) 737--4289 fax (607) 735---5941 Academic Transcript Request

- Complete, sign, and mail this form with the appropriate transcript fee(s)
- ▶ There is no charge for your first request. A fee of \$3.00 is charged for each additional official or unofficial copy.
- Processing time, for all requests is 5 business days.
- ► Transcripts will not be faxed.
- Transcripts will not be released if financial obligations to the School of Radiology have not been met.

Date:			
Social Security Number:	Date of Birth:		
Name:	First		Devices Name (a)
Last	FIRST		Previous Name(s)
Address:			
No. & Street	City	State	Zip
Telephone:			
Ноте	Work		Cell
Email:			
Dates of Attendance:	or	Year of Graduat	tion:
Please check:			
o Official Transcript (with school	l seal)	# requested	
o Unofficial Transcripts		# requested	
Εας	h additional c	opy after the first i	is \$3.00
Applicable fee mo	ust accompan	y this form prior to	release of transcript
Amount enclosed: \$ Checl	k or money ordei	made payable to: Arn	ot Ogden Medical Center School of Radi
Send transcript to:			
Name:			
Address:			
City/State/Zip			
Signature:			