

CAROLINAS COLLEGE OF HEALTH SCIENCES

Transcript Request Form

Please forward an OFFICIAL COPY of my transcript to *(list name and address of each:*

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Name while attending Carolinas College of Health Sciences: _____
 Social Security Number: _____ Dates attended: from (year)____ to (year)____
 Program of enrollment: _____
 Current Name: _____
 Current Address: _____
 City, State, Zip: _____
 Phone: _____
 E-mail: _____

- Check if this address, phone, or email is new since you last contacted the college.
- Check if this name is new since you last contacted the college.
- Check if you graduated from a one- or two-year CCHS program but are not receiving the alumni newsletter regularly.

I authorize the release of my grades and/or a transcript of my academic record to the above.

_____ (Signature) _____ (Date)

Mail/Fax to:
CCHS Registrar < PO Box 32861, Charlotte, NC 28232 < Fax: 704-355-9336

| Transcript Fee | |
|---|---------------------------|
| 1st Request | Free |
| After your 1st transcript | \$5.00 per request |
| Unofficial Transcript | Free |

(Fee proceeds go to the CCHS Alumni Association)

VISA/MASTER CARD FAX Transaction:
Your Name: _____
Name on Card (if different): _____
Type of Card (Circle One) **VISA** **MASTER CARD**
Card Number: _____ **Expiration Date:** _____ **Transaction Amount \$**____.00