Med College

3418 West 84th Street, Suite 106
Hialeah, Fl 33018
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Transcript Request Form

To: Registrar's Office

Student Name: ____

Social Security Number: _______________________ **Phone: (   )** ________________

Email Address: ___________________________________

Send transcript to: ____

Mailing Address: ____

City: ________________________ **State:** _______ **Zip:** __________________

Email Address: __________________________ **Program Attended:** _____________________

I attended your school from: ____

Name at time of attendance: ____

Student's Signature (Mandatory) ______________________ **Date:** _________________

Note: First official transcript is free of charge; a $15.00 Transcript fee will be collected per any additional transcript requested