Memorial and Samaritan Hospital School of Nursing

Members of Northeast Health

Transcript Request

Name:_____ SS#_____/_____/_____

Other Name(s) used:_____ Dates Attended: _____/_____
Mo/Yr Mo/Yr

Program Status: Graduated _____ Date _____/_____
Mo/Yr

Withdrew _____ Date _____/_____
Mo/Yr

Current Address: _____

_____
City State Zip

Day Phone: _____

Send transcript to: _____

_____

_____
City State Zip

Student's signature: _____ Date: _____

Transcript Policy

- Any request for release must be signed by the student.
- No transcript will be released without proper identification.
- Transcripts delivered to students will be stamped "Unofficial".
- Official transcripts must be mailed or presented in a sealed envelope from the School.
- A $5 fee must accompany each transcript request.
- All obligations to the School must be met to release records.
- Allow 3 to 5 business days for processing requests.

* *

For Office Use

Date Sent: _____ By: _____ Held:_____ Reason: _____

Fee Paid: _____