



Request for Transcript of Academic Record
2010 Health Campus Drive, Harrisonburg, VA 22801
(540) 564-7236 FAX: 540-564-7233

Please complete the application, sign, and return to the above address.
Requests may also be faxed. There is no charge for transcripts.

Mail transcript to:

_____ School/Business
_____ Office or Person
_____ Complete Mailing Address

Student Information:

_____ Date of Request
_____ Last 4 digits of Social Security No.
_____ **AND** Date of Birth
_____ Last Name
_____ First Name
_____ Street/P.O. Box
_____ City
_____ State
_____ Zip
_____ Name at time of enrollment (if
different from above)

Currently Enrolled: Yes No

Give Dates of Attendance

From: _____ To _____

Date Transcripts should be sent: _____

Number of Transcripts to be sent: _____

Transcripts will be sent within 2 weeks of request.

Student Signature (required)