

Transcript Request Form

\$10 Fee per transcript

PLEASE ALLOW 48 HOURS TO PROCESS
Must include signature

Mail: Office of the Registrar **Or fax:** 830-217-7765
2100 Memorial Blvd.
Kerrville, TX 78028

***Name:** _____ Date: _____
Last First M.I.

Name when enrolled (if different): _____

***Last 4 digits Social Security #:** _____ ***Date of Birth:** _____ **Student ID #:** _____
if known

***Student Signature:** _____
(Transcript cannot be released without signature)

NUMBER OF TRANSCRIPTS: _____

CHECK APPROPRIATE BOXES:

Program you attended:

- Graduate
- Undergraduate
- Vocational Nursing

Last year attended _____

Reason For Release:

- Possible Employment
- Transfer of Credit
- Graduate School
- Summer admission
- Other (please specify) _____

Release Time:

- Release transcript now
- Hold and release transcript at End of Term

Additional addresses may be listed on back

Send Transcript to (complete address as it should appear on envelope):

Name: _____

Attn.: _____

Number & Street: _____

City, State: _____

Zip Code: _____

***Your Current Contact Information:**

Phone: _____

Address: (include number, street, city and zip code)

Special Instructions, if any:

*****FOR OFFICE USE ONLY*****

Initialed by _____ Date Initialed _____ Number of Transcripts paid for _____

Cash amount \$ _____ Check amount \$ _____ Amount charged \$ _____

Receipt Number: _____ **CLEARED** _____ **NOT CLEARED** _____

