

TRANSCRIPT REQUEST

Please type or print legibly

NAME: _____
 Last First Middle

FORMER/MAIDEN: _____

SOCIAL SECURITY #: _____ DATIME PHONE # _____

ADDRESS: _____
 Street City State Zip

TRANSCRIPT MAILING ADDRESS(ES) - You must provide a complete mailing address.

Transcripts requested _____ X \$5.00 fee per transcript = _____

Federal law requires the signature of the student to authorize the release of academic records.

Signature: _____ Date: _____

Mail your request to: Records Office
Washington State Community College
710 Colegate Drive
Marietta, OH 45750

Fax your request to: (740) 376-0257

METHOD OF PAYMENT:

9 Check 9 Money Order 9 Credit Card 9 Debit Card

If paying by credit or debit card, please provide the following information:

9 DISCOVER 9 MasterCard 9 VISA

Account Number: _____ Expiration Date: _____