

Transcript Request Form



One form is required for each transcript requested. Fee is \$5.00 per transcript

Name _____ SSN _____

Previous or Maiden Name _____

Address _____

City _____ State _____ Zip _____

Day Phone _____ Evening Phone _____

Did you attend before Summer 1989? Yes _____ No _____

Graduate _____ Undergraduate _____ Mail _____ Pickup _____ Hold for Degree Posting _____

Hold for grades (list classes) _____

Print the name, title and address of the person or institution that is to receive the transcript.

Signature _____ Date _____

Request can not be processed without signature and payment in full.

Cash _____ Check# _____ in the amount of \$ _____

Please charge \$ _____ to my VISA _____ MC _____ DISC _____

Account # _____ Expiration Date _____

Signature _____ Date _____

Mail to: Student Administrative Services, Rockford College, 5050 E State St, Rockford, IL 61108 or you may fax your request to (815) 394-5174 - Faxed request must include Credit Card information. If you have any questions related to Transcript Request Orders contact SAS@rockford.edu.

For office use only

PC ID# _____ Date Processed _____ Date Mailed _____