



**PLEASE NOTE**

If your name appears on Accounts Receivable, a transcript cannot be issued. Requests will not be filled unless this form is filled out completely. Transcripts issued to students bear the notation "STUDENT COPY."

Please Send request form to:  
Office of Admissions & Records  
SIU/School of Dental Medicine  
2800 College Ave, Bldg. 273, Rm 2300  
Alton, IL 62002-4700

Date \_\_\_\_\_

Name \_\_\_\_\_  
First Name Middle/Maiden Last Name

Address \_\_\_\_\_

City & State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Social Security No. / Banner No. \_\_\_\_\_

First date enrolled \_\_\_\_\_ Last date enrolled \_\_\_\_\_  
Term Year Term Year

- Will pick up  Send now
- Include Grade Point Average  Include Class Rank
- Send after final grades - indicate for which term \_\_\_\_\_  Send after degree notation \_\_\_\_\_ Yr.
- Send after grade change - Indicate for which course number and term

Number Requested

TRANSCRIPT CHARGES - \$5.00 for each transcript

TOTAL CHARGE \$ \_\_\_\_\_

**SEND TRANSCRIPT TO:**

PLEASE PRINT IN ADDRESS COMPLETELY AND LEGIBLY.

*Do not write below these lines - for office use only.*

- Cleared SIS \_\_\_\_\_ DATE  Bill: \_\_\_\_\_ NAME
- Paid \_\_\_\_\_  CASH  CHECK NO. \_\_\_\_\_
- Prepared/Mailed \_\_\_\_\_ Date