

Transcript Request Form

In accordance with the Federal Family Educational Rights & Privacy Act (FERPA) of 1974 and subsequent amendments, your academic records cannot be released without your consent. All outstanding financial, academic or administrative obligations to the Cleveland Clinic (CCF) must be absolved before a transcript can be processed for release.

Student's Full Name: _____

Maiden/Name While Student: _____
(if applicable)

Current Address: _____

City: _____ State: _____ Zip: _____

CCF ID Number: _____ Date of Birth: _____

Email Address: _____ Phone Number: _____

CCF Program: _____

Dates of Attendance: Start: _____ End: _____

Deliver Transcript to:

Name: _____

Institution/Company: _____

Department/College/School: _____

Address: _____

City: _____ State: _____ Zip: _____

Website: _____

Email: _____

Transcript Options:

Number of Copies: **Official Transcript** – Delivered directly to institution or placed in envelope with unbroken seal. **Unofficial** (Stamped 'Unofficial – Issued to Student')

Delivery Options:

Hold for Pick-up Mail transcript Email transcript Submit transcript electronically to institution

Special Instructions:

Signature: _____ **Date:** _____
(required – type name above to sign) (required)

Office Use ONLY!	Date <input type="checkbox"/> Picked up (or) <input type="checkbox"/> Sent <small>(choose one)</small>	
	Sent by:	