Cleveland Clinic
School of Health Professions

Transcript Request Form

Office of the Registrar

Student Information:

First and Last Name: _____ Student ID #: _____

Name while attending program (if different than above): _____

Mailing Address: _____

Phone: _____ Email: _____

Program: _____

Send transcript to:

☐ Myself

☐ Other

Transcript Type:

☐ Official (*sent via mail)*

☐ Unofficial (*sent via email*)

I hereby authorize Cleveland Clinic's School of Health Profession to send my transcript to:

Name: _____ Email: _____

Mailing Address: _____

Required Signatures:

_____ _____

Student's Signature Date

_____ _____

Registrar's Signature Date