TRANSCRIPT RELEASE FORM
RESEARCH MEDICAL CENTER
SCHOOL OF RADIOLOGIC TECHNOLOGY
6675 Holmes Rd, Suite 660
KANSAS CITY MO 64131
816.276.3390

[PLEASE PRINT]

NAME: _____
Last First Middle Maiden/Other

Current Address: _____
Street City State Zip Code

Phone Number: _____ Dates Attended: _____

Social Security Number: _____ Birthdate: _____

Request for: E-Mail Address: _____

- ☐ Official Transcript
- ☐ Unofficial Transcript
- ☐ Issue to student
  (If requesting an official transcript, it will be in a sealed, signed envelope)
- ☐ Other (specify) _____

CURRENT STUDENTS ONLY (please check one):

- -Send transcript now
- Send transcript after grades are posted (will take a ***minimum*** of 30 days after end of quarter)

Mail my transcript to:

_____
Name of College/Organization

_____
Attention

_____
Street Address

_____

_____
City State Zip Code Telephone Number

_____
Signature Today's Date

IN SIGNING THIS FORM, I UNDERSTAND IT WILL TAKE AT LEAST 10 WORKING DAYS FROM THE DATE THE RADIOLOGY SCHOOL RECEIVES THIS REQUEST FOR MY TRANSCRIPT TO BE MAILED OUT.

Return this form to:
Research Medical Center
School of Radiologic Technology
6675 Holmes Rd, Suite 660
Kansas City MO 64131

Email this form to Vicki Fayard: vicki.fayard@hcamidwest.com

Or Fax it to: 816.276.3388; Attention: Radiology School