International American University — College of Medicine
Office of Registrar
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Transcript Request Form

Print your name and address

Name: _____
Last First Middle Iniital

Address: _____
Street

_____
City State Zip Code

_____
Email Address Phone #

Hold for current semester grades? ☐ Yes ☐ No _____
Specify Semester

Graduated: ☐ Yes ☐ No If yes, date: _____ Degree _____

Transcript requested: ☐ Official Copy (sent to recipient below) ☐ Student Copy (sent to the student, unofficial)

Please send an official transcript of my academic records from: _____ to _____
to the address indicated below:

Print full name and address below of recipient

Name: _____
University/College Name

Attn: _____
Name

Address: _____
Street

_____
City State Zip Code

Each Transcript is $25

Check/money order enclosed for: $ _____

Other:(for Visa/MC call Dallas office) $ _____

_____ _____
Student Signature Date

Do not write in space below – for office use only

Rec'd	Sent	Paid