Transcript Request Form

(Transcript(s) can only be requested by student of record. Please allow 2-7 business days to process your request.)

Student of Record

Legal Name while Attending:
Date of Birth: / / Social Security Number:
Current Phone Number:

Please check an option and input quantity for Transcript:

- Unofficial Copy ($0) #_____
- Official (signed and sealed - $5 per copy) #_____

Delivery Information

Please check an option and provide complete mailing information if applicable.

- Mail to:
  Institution Name/Self: _____
  Attention to: _____
  Street Address: _____
  City/State/Zip: _____
- In person pick up: (check one and input information)
  _____ Self _____ Authorized 2nd party (must show Identification)
  Name: _____
  Date of birth: _____
- Electronic: (only for unofficial copy)
  Email Address: _____

I hereby authorize a one-time release of transcript(s)

Signature: _____ Date: _____

(Office personnel only, see back)

IOAH FORM - 03.1

THE INSTITUTE OF ALLIED HEALTHCARE

OFFICE USE ONLY
Telephone request completed by:
Purpose of Telephone request:
Date: / /

Admission/Staff Member Signature: _____

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