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STUDENT INFORMATION

NAME: (First) _____ (Middle) _____ (Last) _____

NAME WHILE ATTENDING SCHOOLS: _____

E-MAIL: _____ DATE OF BIRTH: ____ | ____ | ____

PHONE: _____ SOCIAL SECURITY NUMBER: ____ | ____ | ____

INSTITUTION INFORMATION *(For internal use only)*

SCHOOL NAME: _____ ONLINE: ☐ Yes ☐ No

CITY: _____ STATE: _____ DATES ATTENDED: _____ TO: _____

DEGREE EARNED: _____ CREDITS EARNED: _____

	REQUEST FOR OFFICIAL TRANSCRIPT
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TRANSCRIPT RELEASE AUTHORIZATION

By signing this form, I am authorizing you to send my official transcript to Waldorf University. I am also authorizing Waldorf University to mail/fax this Transcript Request Form to you, and to pay the transcript fee on my behalf.

STUDENT'S SIGNATURE: _____ DATE: ____ | ____ | ____

**Student signature is required*

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