DANVILLE REGIONAL MEDICAL CENTER
SCHOOL OF HEALTH PROFESSIONS NURSING PROGRAM
142 S. Main Street
Danville, Virginia 24541
Phone: (434) 799- 3803 or 434 799-4443 Fax: (434) 799-4563

TRANSCRIPT REQUEST

Allow 7-10 days for request to be processed

Student Name: _____ Last Date Attended: _____

Class of: _____

SSN# _____

Former Name: _____ (if applicable) Date of Birth: _____

Phone number: _____

Address: _____
City Zip

Fee: $10.00 for each transcript **Amount Due to complete request $ _____**

Total number of copies requested: ____ # of **Official copies** (sealed copy) ___ # of **Unofficial copies** ____

☐ Pick up

☐ Fax _____
Name of Business and Contact person Fax number

☐ Mail to _____
Name of Business and Contact person

_____
Address City State Zip

Checks payable to: DRMC School of Health Professions

Charge Card request by phone:
I approve DRMC School of Health Professions to charge my account in the amount of $ _____

☐ MasterCard ☐ Visa
☐ Discover ☐ American Express

_____ _____ _____
Card number Expiration date V-code (3 digit No.)

NOTE: Failure by the student to pay proper financial obligations may result in the withholding of official transcripts. In accordance with the Family Educational Rights and Privacy Act of 1974, the attached record is being released with the consent of the student. This authorization does not permit you to transmit this information to other individuals, agencies or organizations other than yourself and in order to do so; you must secure the written consent of the student.

_____ _____
Signature Date

For school use:

☐ Picked up ☐Faxed ☐ Mailed Date____/____/_____ Total Fee paid: _____

Request completed by: _____

(07/93 ss, Reviewed 12/02 ag,Updated 08/05 ch, revised 7/06 lp, revised 11/07dp, revised 12/08 dp, revised 2/09;07/13; 5/14; 5/16)